

PHR_{plus} Knowledge Building Agenda

March 2002

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Mission

The Partners for Health Reformplus (PHRplus) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHRplus promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *better informed and more participatory policy processes in health sector reform;*
- ▲ *more equitable and sustainable health financing systems;*
- ▲ *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- ▲ *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHRplus advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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The opinions stated in this document are solely those of the authors and do not necessarily reflect the views of USAID.

Abstract

PHR*plus* is required to produce a Knowledge Building Agenda to guide research activities under the project. The first part (Part A) of the Knowledge Building Agenda reviews (i) ongoing PHR*plus* work (primarily technical assistance activities) with a view to identifying research needs and opportunities (ii) user demand for health systems research based upon a small survey of U.S. Agency for International Development mission staff and developing country health policymakers and (iii) emerging trends in health systems research. These three building blocks are used to identify a number of possible research areas from which five were selected for further elaboration. The five selected were:

- ▲ Approaches to strengthening accountability;
- ▲ The equity and sustainability of community-based health insurance as part of a national health system financing strategy;
- ▲ Hospital autonomy and the role of hospitals within reformed health care systems;
- ▲ Regulation and the quality of private health care providers in developing countries;
- ▲ Health worker motivation in reform contexts.

In Part B of the agenda short concept notes for each of the five research areas are presented. Each concept note briefly addresses the current state of knowledge with respect to this topic, arguments for why it is an appropriate research focus for PHR*plus*, potential research questions, and the research approach.

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Acronyms

APHEN	Asia–Pacific Health Economics Network
CAP	Country Assistance Plan
CBHI	Community-Based Health Insurance
CMH	Commission on Macroeconomics and Health
DFID	Department for International Development
FSU	Former Soviet Union
HEPNet	Health Economics and Policy Network
IDRC	International Development Research Centre (Canada)
ILO	International Labor Organization
IRD	Intensive Research and Demonstration
LAC	Latin America and the Caribbean
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHA	National Health Accounts
PAHO	Pan American Health Organization
PHN	Population, Health and Nutrition
PHR	Partnerships for Health Reform
PHR_{plus}	Partners for Health Reform _{plus}
PRSP	Poverty Reduction Strategy Paper
SO	Strategic Objective
TAG	Technical Advisory Group (to PHR _{plus})
USAID	United States Agency for International Development
SWAP	Sector-Wide Approach
WCA	West and Central Africa
WHO	World Health Organization
WHR	World Health Report

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Executive Summary

Part A: Development of the Knowledge Building Agenda

While Partners for Health Reform*plus* (PHR*plus*) is primarily a technical assistance project, the structure of the project gives knowledge building an instrumental role in terms of informing and improving technical assistance, and complementing routine monitoring processes. The Knowledge Building agenda presented here encompasses all cross-cutting research activities: it does not address other project research work that is specific to any of USAID's strategic objectives (child health, maternal and reproductive health, HIV/AIDS, and infectious diseases).

There were three main influences upon the development of this agenda, namely:

- ▲ ongoing PHR*plus* work, in terms of demand from the field, knowledge gaps faced by those providing technical assistance, and opportunities for piggy-backing research onto technical assistance;
- ▲ user demand for health systems research as reflected by the results of a small survey of USAID mission staff and developing country health policymakers;
- ▲ emerging trends in health systems research as revealed by a review of key recent documents in the health systems field, research agenda compiled by other groups, and discussions with other researchers and staff of international organizations.

While PHR*plus* has a diverse work program there are some areas where there is clearly substantial demand for technical assistance and a need for greater understanding of reform strategies and impacts. These areas or strategies include decentralization, community-based health insurance (CBHI), autonomous hospitals, regulation, and stakeholder/community engagement. The PHR*plus* contractual documents highlight a number of underlying themes. For example, work upon CBHI links very directly to means to offer financial protection to the poor against the costs of ill health. Similarly, accountability issues underlie work on both decentralization and autonomous hospitals.

The dominant theme emerging from user responses to the survey was a concern with improving access for the poor to health care services of all sorts. This concern was also reflected in a substantial demand, particularly among the policymaker group, for more research work on health financing mechanisms. The interest in health financing mechanisms seems to reflect issues relating to both financial accessibility and sustainability. More surprising was the considerable demand for work related to quality of care and to accountability. Research on autonomous hospitals was also thought to be needed. Perceived to be of less high priority, but also favored, was research on regulatory issues, sequencing of reforms, human resources (including health worker motivation), and information and planning.

Predictably, review of key international documents and research agendas threw up a diverse range of topics. Reflecting initiatives in the global development agenda there was found to be a strong focus on the very poor and how health system reform initiatives affected this group. In addition to the

topics already identified above, the global literature placed emphasis upon the changing role of government and how governments may play a stronger stewardship role, on human resource management issues, and on the notion of responsiveness.

Based on these three main influences, we identified a range of possible research topics including: accountability, community-based health insurance, pro-poor policies, hospital autonomy, quality of care regulation, responsiveness of services, information use (e.g., by communities), contracting and quality of care, and health worker motivation. The paper discusses criteria for appraising these alternatives and then, using these criteria, presents a short list of five research topics. Table ES-1 below summarizes the short list of topics considered and criteria used to select from them. Topic areas presented in bold represent those finally selected to present to the PHR*plus* Technical Advisory Group (TAG). Summaries of each these five research topics are presented in Part B of the document.

Table ES-1: Priorities across Possible Research Topics

Topic Area	Links to PHR <i>plus</i> Technical Assistance	User Demand	International Interest	Other Comments
Accountability	High (e.g., through hospital autonomy, regulation)	High	Emerging topic	Cross-cutting topic Strongly supported by TAG
Community-based health insurance	High	High	Very high	PHR reputation Strongly supported by TAG
Extending social health insurance	Moderate	High	High	Very similar work being implemented by International Labor Organization in Latin America and the Caribbean
Pro-poor policies	Moderate	High	Very high	Cross-cutting topic Substantial work planned by Monitoring and Evaluation team
Hospital autonomy	High	Moderate	Emerging focus on hospital policy	
Quality of care regulation	Moderate	Moderate	High to stewardship	
Responsiveness of services	Moderate	Low	High (World Health Report)	
Information use (e.g., by communities)	High	High	Moderate	Likely to occur as part of Intensive Research and Demonstration activities. Also substantial amount of work on this topic planned using SO5 funds.
Contracting and quality of care	Moderate	High	Moderate	Workplan of the Health Systems Development Group at the World Bank covers this.
Health worker motivation	Moderate	Moderate	Moderate	Builds upon research previously conducted under Partnerships for Health Reform. Interest from the field in certain dimensions e.g., handling motivational issues through reform processes such as decentralization.

Part B: Proposed Research Topics

Approaches to strengthening accountability within health systems

The current concern with accountability in health systems reflects not only the size and potential impact of health systems, but also current dissatisfaction with system performance. Existing accountability literature can be grouped into three areas: financial accountability, accountability for performance, and political/democratic accountability. In the health sector literature accountability is often not the dominant theme, but rather is applied to particular aspects of the system such as community participation, health system governance, or health financing. Accountability is suggested as a *PHRplus* research focus because it is currently a very high-profile topic, and there is lack of conceptual and empirical integration, and significant potential for leveraging health sector strengthening activities. Suggested strategies are: to prepare a background paper addressing some broad topic areas and to search for field opportunities to pursue investigation of operational issues where accountability concerns are prominent. Hospital autonomy and decentralization are particularly promising areas where *PHRplus* has substantial technical assistance activities and concerns about accountability are dominant.

Community-based health insurance

Interest in community-based health insurance schemes has been increasing since the mid-1990s. CBHI schemes are defined here as those managed and operated by an organization other than government or a private for-profit corporation, that provide some form of risk pooling to cover the costs (or part thereof) of health care services. While much effort has been taken by Partnerships for Health Reform (PHR) and other projects to strengthen the design and implementation of CBHI schemes, there is little empirical and evaluative information currently available in association with existing schemes. One notable exception is the evaluative studies of the Rwanda CBHI scheme initiated by PHR. Two other systematic reviews of CBHIs are the synthesis paper developed by the Commission on Macroeconomics and Health and the forthcoming edited volume on reinsurance of CBHI that was jointly undertaken by the International Labor Organization (ILO) and the World Bank. Both of these papers build on previous work rather than analyze new data. CBHI is suggested as a *PHRplus* research area because it is currently a high-profile topic, there is little empirical or evaluative evidence, *PHRplus* can build on the track record in this area of PHR and the Health Financing and Sustainability projects, and there are significant opportunities to build on ongoing *PHRplus* technical assistance activities. Suggested research areas are: equity and poverty and CBHI, risk and the financial sustainability of CBHI schemes, and CBHI and the role of government. After selection of a research question, a research strategy will be defined that includes a field component.

Hospital Autonomy

The concept of autonomous public hospitals has been of interest to the development community since the early 1990s. Public hospitals typically consume a large share of the public health care budget, and strategies to limit public spending in these facilities are of policy interest. Strategic management and population ecology are conceptual approaches that have been used to study public hospitals in developed countries. These approaches may provide further insight into hospital autonomy work. The strategic management approach suggests that hospitals in the developing world must develop skills and strategies to gather resources from the environment around them. The population ecology framework suggests that the surrounding environment limits the capacity of public hospital management to adapt and gain resources. Certain environmental niches cannot support public hospitals, and expert management alone cannot compensate for these environmental

limitations. In certain of these cases, public subsidies may be needed to support the social goals and health policy objectives. Much of the work in the developing world to date has focused on applied strategic management. We believe that a more solid base for hospital autonomy work needs to be developed by defining models that consider strategic management, hospital environments, social goals, and health policy objectives. These models would be tested in *PHRplus* field sites and disseminated to the development community.

Regulation and the Private Sector in Developing Countries

Developing countries are increasingly interested in regulatory strategies for health care systems. These strategies are frequently a key health reform objective. The focus of this work will be regulation by an external authority that is aimed at changing behaviors within provider organizations to improve quality of care. The assumption that underlies this focus is that external regulatory influences exerted by capable external institutions can improve the quality of health care provided to consumers. Existing literature identifies both positive and negative effects of regulatory approaches to improve health care quality. Many studies have found that if not properly designed, regulation can lead to negative provider behavior, thus obstructing what regulation is designed to promote. In the development context, more practical evidence is needed about successful implementation of regulation in developing countries. This topic is of interest to *PHRplus* because there is a clear need for better evidence on the actual impact and effectiveness of regulatory interventions in developing countries, as well as a clear interest in this area by the major donors, and previous PHR work can be a basis for more in-depth study. *PHRplus* research will explore the binding constraints that prevent effective implementation of health regulatory strategies in the developing countries. Several factors are identified for further investigation: medical ethics, trust and accountability, capacity of regulatory organizations and providers, and the availability of meaningful standards. Next steps include a conceptual model that leads to a checklist of factors. This checklist will be tested in field sites and will then be developed into a tool to assist policymakers to identify key factors that should be addressed in the development and implementation of regulation.

Health Worker Motivation

A renewed interest and effort is being made worldwide on human resource management, and motivation is a key component in health workforce performance. Effective health service delivery requires the efficient use of the skills of a well-motivated health sector workforce. Evidence of poor worker motivation can be seen across many countries at different levels of development.

PHR developed a conceptual framework for the determinants and consequences of health worker motivation and applied the framework to assess motivation of hospital workers in Jordan and Georgia. There is very little other empirical evidence from the developing world on this topic. It is proposed that under *PHRplus* the conceptual framework be expanded to incorporate a variety of interventions designed to improve health worker motivation, such as improved communication, better job design, increased accountability, better recruitment and selection procedures, improved leadership and teamwork, stronger links to the community, and opportunities for community feedback. *PHRplus* would then identify field sites where baseline data collection on key determinants and outcomes of health worker motivation would be collected. Following the baseline a consensus building format would be used to identify appropriate interventions to improve worker motivation that would be implemented, and later evaluated. *PHRplus* is considering how to link this work to existing technical assistance activities. For example, field staff have noted concerns about how health worker motivation is affected by substantial organizational reforms such as decentralization or increased hospital autonomy. There may also be scope to link this topic to work on human resource issues in contexts with high HIV-prevalence rates.

Part A: Development of the Knowledge Building Agenda

1. The Partners for Health Reform*plus* Project and Knowledge Building

Partners for Health Reform*plus* (PHR*plus*) is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform (PHR) project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on infectious disease surveillance, information systems that support the management and delivery of appropriate health services, and community/stakeholder participation.

The PHR*plus* project supports health system strengthening and advances knowledge about health sector problems and how to resolve them. While the overall objective of the project is to improve health system performance in delivering population, health, and nutrition (PHN) priority interventions¹, PHR*plus* focuses upon five result areas, namely:

- ▲ Implementation of appropriate health system reform;
- ▲ Generation of new financing for health care, as well as more effective use of existing funds;
- ▲ Design and implementation of health information systems, with a particular focus on those for disease surveillance;
- ▲ Delivery of quality services by health workers;
- ▲ Availability and appropriate use of health commodities.

PHR*plus* has a global focus that may encompass work in Africa, Asia, Latin America and the Caribbean (LAC), the Middle East, and Eastern Europe.

The PHR*plus* contract states that the project shall “design, implement, analyze, disseminate and apply the results of high quality applied, operations and evaluative research” and that during the first year of the contract an agenda of six to eight research topics will be identified.

1.1 The Role of Research within PHR*plus*

PHR*plus* is primarily a technical assistance project, but the structure of the PHR*plus* project gives knowledge building activities an instrumental role in a number of different respects. Knowledge building activities can:

¹ The Global Bureau of USAID identified five priority interventions namely: family planning, child survival services, maternal health services, HIV/AIDS, and infectious disease services.

- ▲ Advance knowledge at the global and individual country levels to better identify operational constraints to the delivery of PHN interventions and assess alternative strategies to alleviating these obstacles.
- ▲ Inform and improve upon technical assistance and training that the project provides in specific countries. In this way the results of applied research can feed directly back into advice given to policymakers in specific countries.
- ▲ Complement the routine monitoring processes of the project. Routine monitoring seeks to assess the extent to which project activities are meeting their anticipated targets; research can investigate particular circumstances where this does not appear to be occurring.
- ▲ Contribute to the development of tools and methodologies that can be disseminated and applied in many countries.

The project is encouraged to pursue multi-country studies, as it is felt that such studies are more likely to render results that can be applicable across many different settings. However, the *PHRplus* contract also states that in order to facilitate the completion of more intensive systems development and operations research work, the project should work in three intensive research and demonstration (IRD) sites².

Knowledge building under the *PHRplus* project is not limited by any set of methodologies or approaches.

1.2 Scope and Purpose of Knowledge Building Agenda

This document constitutes the Knowledge Building Agenda referred to in the *PHRplus* contract, and will be used to guide Knowledge Building activities within the project.

The agenda is meant to encompass all cross-cutting Knowledge Building activities. In addition to the Knowledge Building described here, *PHRplus* has a number of “Special Initiatives” that conduct work, including research, on USAID Strategic Objectives (SOs) (child health, maternal and reproductive health, HIV/AIDS, and infectious diseases). This agenda does not attempt to discuss or set priorities for these SO-specific activities, as priority setting within these areas is normally carried out through consultation between the *PHRplus* team and the concerned USAID SO team.

The Monitoring and Evaluation (M&E) team of *PHRplus* also conducts a range of activities including internal project monitoring, technical leadership and capacity building in M&E, and evaluative research. While this agenda refers to some of the evaluative research likely to be conducted by the M&E team, it does not discuss this in any great detail.

The focus of this agenda is the Knowledge Building activities that will be conducted by the Applied Research team.

This agenda considers and discusses broad areas of potential research and possible research questions. It does not consider in any detail implementation issues (such as where research will be

² A separate document discusses the *PHRplus* strategy for developing and managing these intensive research and demonstration sites (Bennett et al. 2001).

conducted or by whom). Upon approval of this agenda more detailed scopes of work for approved research areas will be produced.

1.3 How the Knowledge Building Agenda was Developed

There are two parts to this document. Part A provides the context to the agenda development, the influences upon the agenda, and identifies a number of likely agenda topics. Part B consists of a series of concept notes that explores each potential topic in rather more depth.

Any review of recent publications indicates that there are a large number of possible topics within the area of health system strengthening that warrant further research (Oliveira-Cruz, Hanson, Mills 2001, Pan American Health Organization/World Health Organization/International Development Research Centre 2001, WHO 2000). The challenge facing the development of this Knowledge Building agenda is to select research areas where there is a good fit for *PHRplus*. Figure 1 illustrates how this problem has been conceptualized by the Knowledge Building team.

First, Knowledge Building efforts conducted by *PHRplus* are likely to constitute better value for money, and potentially have greater impact if they build upon areas in which the project is already working or mandated to work. Consequently there are a number of internal influences upon the direction that the Knowledge Building agenda has taken. These are reflected within the triangle representing *PHRplus* in Figure 1 and are discussed at more length in Section 2 of this document.

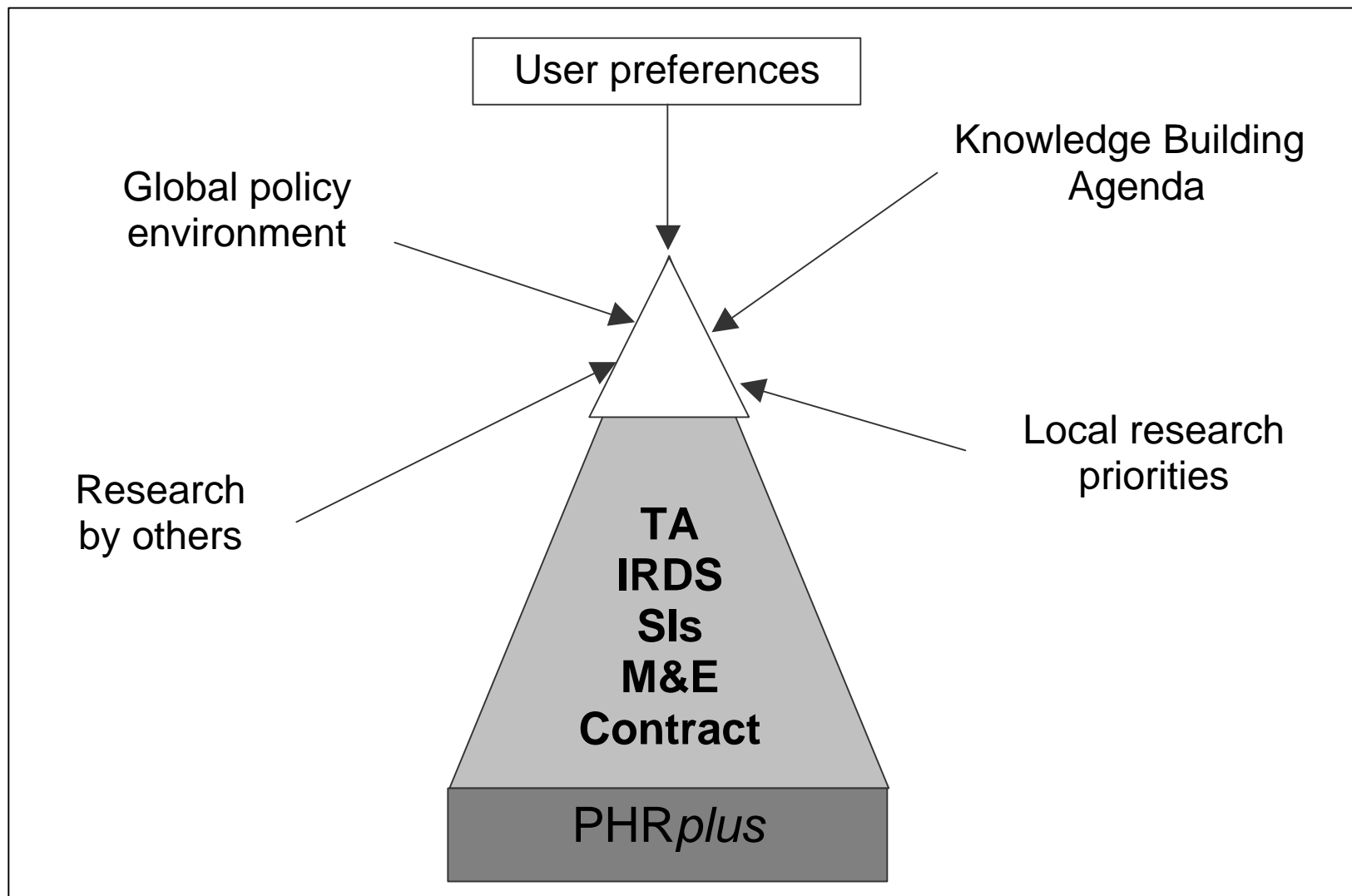
Second, the Knowledge Building team attempted to take into account the preferences of users of *PHRplus* research. This task was more complicated than it might seem at first due to multiple possible types of users and their geographical spread. While the official client for *PHRplus* work is USAID, research in this area is also likely to be used by a number of other stakeholders, including developing country policymakers and the staff of international organizations. *PHRplus* attempted to elicit the views of these various groups, and these are presented and discussed in Section 3 of the document.

Third, there are a number of external factors that affect what makes sense for *PHRplus* to conduct research on. The Knowledge Building team of *PHRplus* seeks both to be at the cutting edge of applied research in this area and build upon its comparative advantage. Section 4 of this document reviews emerging trends in research on health systems strengthening and seeks to identify *PHRplus*'s strengths in this area compared to other research organizations.

Section 5 builds upon these previous sections. It develops criteria for assessing the topics that *PHRplus* should work on and presents arguments to support *PHRplus* involvement in the short list of topics identified.

These three sets of influences helped the Knowledge Building team to identify a shortlist of research areas where it might be able to make a significant contribution. An initial draft of the Knowledge Building Agenda was discussed with the project cognizant technical officers, key project staff and the project Technical Advisory Group (TAG) prior to finalization. The TAG supported the agenda as it stood, but expressed particular interest in and support for the research in the areas of community-based health insurance, accountability, and health worker motivation.

Figure 1: Influences on Knowledge Building Agenda



2. Internal Influences upon the Knowledge Building Agenda

2.1 Applied Research Conducted under PHR

The PHR*plus* contract notes that research priorities should build upon prior research conducted under predecessor projects. This makes sense in terms both of building upon expertise available to the PHR*plus*, and building work in areas where the project already has a reputation.

Under PHR, multi-country applied research studies were conducted in six major areas that are described briefly below:

- i. The policy process of health care financing reform in South Africa and Zambia: a retrospective study, combining multiple research techniques (particularly qualitative approaches) that explored the factors affecting the policy process, and how policy processes affected policy content and ultimately policy success (Gilson et al. 2000).
- ii. The impact of provider payment reform upon service delivery patterns and provider organization: a three-country study covering Argentina, Nicaragua and Thailand that explored the impact of the adoption of capitation payment upon relative balance of services between primary and secondary levels, and provider organization (Bitran et al. 2001).
- iii. Equity in the financing and delivery of health care services: a multi-country study applying equity analysis techniques developed to consider equity in the financing and delivery of health services (Makinen et al. 1999).
- iv. Increasing the coverage of priority services: development and application (to Egyptian data) of an economic model comparing alternative strategies to expand coverage of a priority service. The strategies considered included: contracting private providers, expanding public sector coverage, and information provision to consumers (Berman and Chawla 2000).
- v. The determinants and consequences of health worker motivation: development of a conceptual framework to exploring the influences upon health worker motivation in the context of health sector reform. Development of tools to measure determinants and consequences of health worker motivation and application of these tools in Georgia and Jordan (Franco et al. 2000, Bennett et al. 2000).
- vi. The impact of decentralization upon service utilization and priority setting at the local level including a review of rules and regulations set by central government to influence local-level decision making in several countries and an in-depth study in Zambia (Bossert et al. 2000).

While all of these research studies produced policy relevant findings that have since been published in peer reviewed journals or referenced elsewhere.

2.2 Contractual Considerations

The PHR*plus* contract does not pre-specify a research agenda but rather requires that the contractor develop a research agenda during the first year of the contract. The contract does however suggest a number of factors that the project should take into account in identifying priority topics (including prior PHR research), and it also emphasizes that strong links should be made to technical assistance activities. In particular it was envisaged that countries where PHR*plus* established “Intensive Research and Demonstration” sites would provide particularly good platforms for research. The contract notes that:

These programs will coordinate implementation of operations research and demonstration activities, particularly in the areas of decentralization and more effective mechanisms for expanded stakeholder participation, quality assurance, financing and health information and infectious disease surveillance systems.

A further theme that runs through the contract is the need to build an evidence base that highlights the causal linkages between:

Identification of operational constraints	=>	Implementation of corrective measures	=>	Improved delivery of PHN interventions
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This theme reflects preoccupations within USAID about how health systems affect PHN services, but also a broader concern about the lack of a solid informational base upon which to base decisions regarding appropriate health system strengthening strategies. This theme links particularly closely to monitoring and evaluation, which is one of the reasons why both applied/operational research and evaluative research efforts are considered in this agenda.

The Abt Associates Inc.-led consortium was required to submit as part of its proposal suggested topics for applied research. The list of these topics is provided in Box 1. The topics should be regarded primarily as illustrative. The agenda presented here has the mandate to update, review, and replace any prior suggestions. However, it is interesting that many of the topics listed in the proposal are still resonant and reflect the type of questions that, to date, PHR*plus* has been asked to address. In particular the emphasis upon improving services for the poor is a theme that has emerged frequently in consultations with both USAID and non-USAID groups.

Box 1: Ideas for Research included in the Report

- ▲ Assessing the impact of health sector strengthening strategies on priority services and the poor
- ▲ Further developing innovative financing schemes for priority services to address the needs of the poor
- ▲ Developing informed stakeholder involvement to encourage appropriate system strengthening strategies
- ▲ Improving health worker performance through motivational interventions
- ▲ Strengthening the role of non-governmental organizations (NGOs) and commercial providers in providing priority services and meeting the needs of the poor
- ▲ Enhancing capacity to steer the health sector
- ▲ Analyzing health systems performance through a multi-country database

2.3 Demand for PHRplus Technical Assistance

Figure 2 summarizes the primary areas in which PHRplus has (to date) been requested to provide technical assistance. It reflects only the countries with large-scale PHRplus activities³. There are a number of themes for which there appears to be a particularly marked demand. In the sub-Saharan Africa region community-based health insurance/*mutuelles* is a focus of much work, particularly in West Africa but also in East Africa. While contracting appears also to be a dominant theme, it seems unlikely that the Honduras country program will proceed with this, and the examples cited from West Africa focus upon contracting by *mutuelles*.

An issue that appears of relevance in virtually every region in which PHRplus is working is decentralization – it is surprising that only three of the CAP countries specifically identify this as an area of work. The nature of the demand for technical assistance related to decentralization varies somewhat, but in many cases PHRplus has been asked to strengthen decentralized planning and budgeting processes, sometimes with a particular focus upon enhancing community involvement. Technical assistance on the related issue of hospital autonomy is also in demand, with agreed activities in Jordan, Malawi, and Eritrea.

Surprisingly, regulation emerges as being an area where PHRplus has a considerable volume of work planned, primarily focusing upon strengthening regulatory capacity to improve quality of care. The regulatory work in West and Central Africa (WCA) focuses upon regulation of CBHI-type schemes.

There is also a substantial demand for work on the development of infectious disease surveillance systems.

³ It is based upon Country Assistance Plans (CAPs) that cover countries with programs of \$250,000 or more.

Figure 2: PHR*plus* Activities Planned in Countries with Country Assistance Plans

Strategies	Honduras	Jordan	Georgia	Albania	Ghana	Benin	Malawi	Tanzania	REDSO	WCA	N
Raise Revenue											
General											2
User Fees/Exemptions											2
Drug Funds											1
MHOs/CBHF											4
Social Insurance											1
Reallocate Resources											
General TA Support											4
Targeting											2
Contracting											4
Essential Health Package											3
Develop Alternative Organization of Service Delivery Resources											
Decentralization											3
Hospital Autonomy											2
Primary Care Model											2
Referral Guidelines											1
Change Laws and Regulations											
Regulation											4
Health Information Systems											
General TA Support											1
Disease Surveillance											3
HMIS*											3
NHA**											4
Other Strategies											
SWAP*** Support											1
Provider Self Assessment											2

* Hospital Management Information Systems

** National Health Accounts

*** Sector Wide Approach

2.4 The Knowledge Building Agenda and Intensive Research and Demonstration Sites

PHR*plus* is in the process of identifying three countries where it will develop “Intensive Research and Demonstration” sites. An IRD site is said to be:

A defined geographical entity, where PHR*plus* is engaged (through its technical assistance activities) in substantial health system strengthening over a period of years, that is supplemented by work in a number of different task areas such as monitoring and evaluation, research, capacity building, stakeholder participation, etc. The overall effort should:

- ▲ help demonstrate to key stakeholders the effectiveness (or otherwise) of the intervention;
- ▲ inform local and national reform agendas and implementation;
- ▲ enhance international understanding of health system strengthening issues.

Ideally there should be scope for replicating/rolling out the pilot intervention. (Bennett et al. 2001)

In each IRD site the core of the activities will focus around a structured evaluation of the intervention being implemented. This evaluative research is not discussed in any depth here as it is driven primarily by the activities defined in the CAP. However there will probably be scope for supplementary research and hence the activities proposed for IRD sites are particularly relevant to the development of the knowledge building agenda.

The two countries where it appears most likely that PHR*plus* will proceed with the establishment of IRD sites are Albania and Honduras. Table 1 summarizes the possible topics to be addressed in these sites. These topics/activities reflect primarily the requests of the missions in the countries, but also the PHR*plus* staff’s opinion on how planned activities can contribute to global knowledge building.

Table 1: Core Issues to be Addressed in IRD Sites

Albania	Honduras
<ul style="list-style-type: none">▲ Decentralization: develop local health planning and budgeting capacity▲ Examine effect of improvements in quality of care upon accountability▲ Stakeholder work to create a more supportive policy environment for decentralization▲ Examine the effects of increased information on the perceived accountability of the health sector▲ Quality of care regulation	<ul style="list-style-type: none">▲ Decentralization: strengthen local planning and budgeting capacity and evaluate▲ Community involvement: examine informational needs of communities in decision making, and links to accountability▲ Government capacity to regulate (particularly licensing)

It is apparent that there is substantial overlap between the activities planned in Albania and Honduras. In particular, work in both countries will encompass (i) various themes within the topic of decentralization (ii) work with community-level stakeholders, including their involvement in planning, and strengthening accountability mechanisms, and (iii) quality of care regulation.

PHR*plus* is trying to identify a country in sub-Saharan Africa as a third IRD site. Malawi is one possibility: this would offer opportunities for work on decentralization, and the changing role of the hospital. Ghana is a further possibility, where PHR*plus* is engaged in substantial activities on community-based health insurance and also on disease surveillance systems.

2.5 Summary: Internal Influences

While PHR*plus* has a diverse work program, there are some areas where there is clearly substantial demand for technical assistance and a need for greater understanding of reform strategies and impacts. These areas or strategies include decentralization, community-based health insurance, autonomous hospitals, regulation and stakeholder/community engagement. The PHR*plus* contractual documents highlight a number of underlying themes. For example, work upon community-based health insurance links very directly to means to offer financial protection to the poor against the costs of ill health. Similarly accountability issues underlie work on both decentralization and autonomous hospitals. Concern about the appropriate role for government and stewardship issues are intimately linked to the question of an effective regulatory role for government.

3. User Preferences over Research Topics

PHR*plus* developed a self-administered questionnaire to ask potential research users about their preferences over different types of research topics. A copy of the questionnaire is attached as Annex A. The questionnaire used a Likert scale format and asked respondents to rank both overall research areas and specific topics within those areas on a scale from (1) “very unimportant” to (5) “very important.” The overall research areas were nine, corresponding to the project’s own intermediate results (effective health policy, health care financing, organization and management, quality of care) and the five USAID SOs (family planning, child health, maternal and reproductive health, HIV/AIDS, infectious diseases and disease surveillance).

It was decided that random distribution of the questionnaire to missions would most likely meet with a poor response, hence sample selection was non-random. PHR*plus* staff selected missions on the basis of good relations and the likelihood of their responding. Questionnaires were sent out to 11 missions and (after substantial follow-up) 10 responses were received. One of the responses was not entered into the database for analysis as the respondent had chosen to answer only a handful of open-ended questions.

A second group of potential users of PHR*plus* research are policymakers in developing countries. Again random distribution of the survey was ruled out as being too labor intensive and unlikely to lead to high response rates. Instead PHR*plus* took advantage of the presence of a group of developing-country policymakers attending a short-term training course at Abt Associates Inc. and distributed the questionnaire to this group of 30 persons. Thirteen responses were received from this group of respondents.

While the USAID mission respondents reflect a fairly even geographical distribution, the respondents from the training course were much more clustered and included six Ethiopians, two Zambians, two Egyptians, one Jordanian, one Armenian and one person of unknown nationality.

3.1 Quantitative Responses to Survey

Table 2 shows the ranking of broad topic areas according to whether the respondent was a USAID mission staff member or one of the participants at the training workshop (policymakers). Higher scores indicate higher priority.

Table 2: Scores for Broad Research Areas

Broad Research Area	Mean Score Missions	N	Mean Score Policymakers	N
Policy Development	4.00	9	4.69	13
Health Care Financing	4.67	9	4.83	12
Organization & Management	4.22	9	4.42	12
Quality	4.43	7	4.67	12
Family Planning	3.57	7	4.42	12
Child Health	3.86	7	4.42	12
Maternal and Reproductive	4.14	7	4.75	12
HIV/AIDS	3.63	8	4.00	12
Infectious Disease & Surveillance	4.25	8	4.31	13

Missions demonstrated substantial support for PHR*plus* research work on cross-cutting systems issues (as opposed to studies on specific priority services)⁴. Out of all the broad areas identified in the questionnaire, missions perceived the greatest need for work in the area of (i) health care financing (ii) quality of care, and (iii) organization and management of services.

The policymaker respondents also rated health care financing as the most needed research and also ranked quality highly, but accorded greater importance than the mission representatives to research on policy development.

Out of the specific priority services listed, infectious diseases and disease surveillance work, followed by maternal health, was perceived to be most important by missions. Policymaker respondents rated work on maternal and reproductive health the most highly but gave second priority to family planning and child health. Both groups rated HIV/AIDS lowest. The reason for this probably lies in the fact that HIV is not perceived to be a great threat in the countries where some of the respondents are based. This was confirmed by later analysis.

One of the possible reasons for the rankings described here is that many of the respondents may have seen health financing and similar system issues as being the comparative strength of PHR*plus* and this is why they ranked such topics highly compared to SO-specific topics. Only one respondent explicitly stated this as a rationale for their rating.

Table 3 lists the specific research topics that received the highest ratings by mission staff and policymakers. It should be noted that rankings for the top 10 topics were very closely clustered (i.e., there was no significant difference between topics in the top 10), and that differences in the number of people responding to the question accounts for some of the differences in scores. Nonetheless, taken as a whole, Table 3 provides a good indication of the group of themes that respondents considered important.

⁴ Note this is counter to the existing funding pattern, where the Global Bureau provides significantly more funding to SO-specific issues than research on cross-cutting ones.

Table 3: Ranking and Scores for Specific Research Topics Thought to be Priorities

Topic – Mission staff	Score	N	Topic – Policymakers	Score	N
1. Accreditation & quality improvement methods	4.29	8	1. Social health insurance	4.46	13
2. Access for poor to child health services	4.22	9	2. Contracting	4.46	13
3. Accountability	4.22	9	3. Community-based health insurance	4.38	13
4. Use of information in planning	4.13	8	4. Access for the poor	4.38	13
5. NGOs & marginalized HIV+ populations	4.13	8	5. Equity of financing	4.38	13
6. User fees	4.11	9	6. Autonomous hospitals	4.38	13
7. Access for the poor to care	4.11	9	7. Sustainability of family planning	4.38	13
8. Contracting	4.11	9	8. Cost-benefit analysis	4.38	13
9. Autonomous hospitals	4.11	9	alternative maternal health strategies	4.25	12
10. Access for the poor to maternal and reproductive health services	4.11	9	9. Sequencing of health reforms	4.23	13
			10. Accountability	4.23	13
			11. Accreditation & quality	4.23	13
			12. Access for poor to maternal health services	4.23	13
			13. Referrals for maternal reproductive health	4.23	13
			14. Use of information in planning		
Other topics with scores >4: Changing role of Ministry of Health (MOH), social health insurance, equity, regulation, referrals for maternal & reproductive health care			Other topics with scores >4: SWAPs, insurance regulation, health worker motivation, regulation, pricing family planning services, child health sustainability, financing maternal reproductive health, health worker motivation in high HIV contexts		

One theme that is clear from the ratings of both mission staff and policymakers is a concern with “protecting access for the poor: exemption mechanisms and subsidies” and access for the poor to specific services. The policymaker group also awarded high ranking to several financing interventions (notably social health insurance, CBHI, and contracting), perhaps suggesting that they recognized the logical connection between such financing mechanisms and improved access for the poor. Contracting and user fees were rated highly by the mission group of respondents but the insurance options were less highly rated. Equity of financing, another logically related topic, was also ranked quite high by both groups.

Of the specific topics listed in the questionnaire under the section on “Policy development in health systems strengthening” the topic that received highest ratings by both groups was “Accountability to consumers within the health care system.” Changing roles of the MOH, SWAPs, and sequencing of reforms were also thought to be of some priority for research.

Interestingly decentralization was not a topic area ranked as a high priority by either group, with the exception of one specific form of decentralization, namely, autonomous hospitals.

For the group of mission respondents “Approaches to stimulating quality of care, e.g., accreditation” was ranked most highly. This topic was also among the higher ranked topics of the policymaker group. The other two topics within the broad group on quality that received high scores

were regulation, and health worker motivation. Concern about health worker motivation in contexts with high HIV prevalence was perceived by the policymaker group to be of particular concern.

Fewer of the specific topics listed under the priority service areas were highly rated. The two specific priority service topics that both groups rated highly were (i) information dissemination and the use of information in health service planning and management and (ii) referral networks for expanding skilled attendance at deliveries. The first of these topics was listed under the broad heading of “Infectious disease, disease surveillance in relation to health system strengthening,” but the specific topic area could well reflect a much broader concern with information use, i.e., including information on management, costs, and services and not just infectious disease surveillance information. From the policymaker responses there would also appear to be a concern with sustainability issues as they relate to priority services: sustainability of family planning and child health, as well as pricing of family planning services was thought to be important.

Ratings of topic areas and specific topics were also analyzed according to the country in which the respondent was based. The first breakdown analyzed differences between the four regions represented in the sample (former Soviet Union [FSU], Africa, Middle East and Latin America and the Caribbean); further analysis separated respondents from Africa from the rest of the sample. Not surprisingly these analyses revealed further differences. Respondents from the FSU rated two areas significantly higher than respondents from other parts of the world. These two areas were “Approaches to stimulating quality of care, e.g., accreditation” and “Informal (under-the-table) payments.”

Significant differences emerged between the respondents from sub-Saharan Africa and the rest of the group. Specifically, respondents from the African region gave significantly higher priority than the rest of the group to the following topics:

- ▲ Community-based health insurance
- ▲ Access for the poor: exemption mechanisms and subsidies
- ▲ The impact of decentralization upon PHN priority services
- ▲ Sources (donors, governments, etc.) and uses of HIV/AIDS financing
- ▲ Retention and motivation of health workers in high HIV/AIDS contexts
- ▲ Effectiveness of NGOs in reaching marginalized HIV/AIDS populations
- ▲ Implications for the health care system of the HIV burden.

The last four of these topics all concern HIV/AIDS: it is clear that the higher HIV prevalence rates in sub-Saharan Africa than the other regions included in the survey affected ratings. It is also logical that respondents from sub-Saharan Africa showed greater interest in CBHI given limited formal sector employment in the region. More surprising perhaps is the fact that while African respondents perceived decentralization to be of high priority this was not the case elsewhere.

3.2 Qualitative Responses to Survey

The questionnaire included at the end of each section a space for respondents to provide “further comments” about research ideas in this area. In many cases such questions were not completed. At the end of the questionnaire, respondents were asked specifically whether they were interested in PHR*plus* conducting research in their country, and if so which research topics they would appreciate PHR*plus* involvement in. Of the mission respondents, six out of the nine stated that they had a need for applied research support, and seven out of the nine stated that they would be interested in PHR*plus* conducting research in the country. In many cases the areas cited by respondents as topics on which they would appreciate PHR*plus* research support were very vague (“health systems strengthening,” “health care financing”). This section reviews the qualitative comments made by respondents.

Some of the qualitative comments provided cast greater light on topics already presented in the questionnaire. For example one respondent who ranked disease surveillance highly commented:

Georgia’s health information system and sub-systems have not adapted and developed rapidly enough to keep pace with the changing needs of policymakers and program managers within the context of health reform. Systems for collecting and processing information from health care providers and other sources by different health agencies are fragmented. The result is that useful data cannot be transformed into indicators of policy and management decision-making interest...Georgia needs to develop an overall strategy for improving decision-making support systems for gathering, processing, and distributing data to policymakers and program managers.

These comments suggest that, while in this particular country, work on disease surveillance systems is forming the starting point for addressing these health information system concerns, the underlying concerns are considerably broader.

A couple of respondents commented further upon the theme of accountability. One mission respondent noted the importance of this concern in the context of decentralization reforms:

The stage needs to be set for public accountability at all levels in order for any sort of decentralization or increased autonomy schemes to be met. For example, in order to create effective autonomous hospital boards, the accounting, productivity and other systems need to be in place to evaluate results...so a lot of groundwork needs to be done prior to heading off on any highway towards decentralization and autonomous health care institutions.

The other (African policymaker) respondent who commented upon this theme linked it to a concern about corruption, noting that weak systems were open to political manipulation and that this commonly worked against the interests of the poor.

Several respondents suggested other issues that had not been included in the questionnaire. The most frequently mentioned additional topic related to human resource management and human

resource development⁵. While several respondents simply listed human resource development as a priority for research, others gave more specific ideas. One African policymaker respondent noted the particular problem of brain drain and suggested research on how countries could retain skilled professionals. Another mission respondent from the FSU noted the need to downsize both workforces and infrastructure. A couple of African policymaker respondents reiterated the importance of understanding how the HIV/AIDS epidemic was affecting health workers.

An additional theme that arose in a couple of questionnaires concerned the relative priorities given to primary/preventive care versus hospital care. One mission respondent from LAC suggested as an important area for research:

Fiscal policies which support increased funding for primary and preventive health care, and systems to monitor shifts in budgetary support from curative to preventive and primary care.

A policymaker respondent (from Africa) suggested research into how autonomous district health boards had affected priority given to preventive and promotive health care services.

Other additional themes listed included referral systems, and accidents and injuries.

3.3 Summary: User Preferences

The dominant theme emerging from the user responses is a concern with improved access for the poor to health care services of all sorts. This concern is also reflected in a substantial demand for more research work on health financing mechanisms, particularly among the policymaker group. The interest in health financing mechanisms seems to reflect issues relating to both financial accessibility and sustainability.

More surprising was the considerable demand for work related to quality of care and to accountability. Research on autonomous hospitals was also thought to be needed. Perceived to be of less high priority, but also favored, was research on regulatory issues, sequencing, human resources (including health worker motivation), and information and planning.

⁵ While health worker motivation was specifically listed in the questionnaire, other topics within this broad theme of human resource management/development were not.

4. External Influences upon the Knowledge Building Agenda

4.1 Introduction

The research agenda developed for PHR (Rannan-Eliya et al. 1996) attempted quite a comprehensive literature review across all topic areas within the contract. Given the exponential growth in publications (particularly if internet publications are included) combined with the growth in the scope of the PHR_{plus} contract, it was thought that such a comprehensive approach to reviewing the literature was not feasible. The following sub-section (4.2) reviews some of the key international health system policy documents of the last few years, notably the *World Health Report* (WHR) (2000), and key papers emanating from the Commission on Macroeconomics and Health (CMH) and the World Bank. Section 4.3 then moves on to review research priorities as reflected by various international health research programs, and research agendas developed by partners from developing countries. Section 4.4 summarizes other ongoing research work.

The context within which the literature on health systems has developed is important. One of the principal changes in the international development arena during the past four or five years has been the increased focus upon international development targets and the plight of the world's poor. In May 1996 the Development Advisory Committee adopted a new strategy ("Shaping the 21st Century: The Contribution of Development Cooperation") that defined a set of targets for monitoring progress towards poverty reduction. These goals have since been adopted by several development agencies. Although USAID has not adopted these goals, the increased focus upon poverty is clearly affecting the way that it works, and there is reflection within the organization on the compatibility of USAID sustainable development goals with poverty reduction goals.

The 2000 World Development Report also served to focus international attention upon the alleviation of poverty (World Bank 2000). Recent international agreements have brought greater resources for debt relief. Initially only Highly Indebted Poor Countries applying for debt relief were obliged to develop Poverty Reduction Strategy Papers (PRSPs) but these are now increasingly common as part of Bank and International Monetary Fund concessional lending. In practice PRSPs tend to have relatively few health-related indicators (Walford 2001).

These broader developments have inevitably brought changes within the health sector too. In recognition that traditional project aid is commonly less effective than it should be, several countries have implemented Sector Wide Adjustment Programs that incorporate donor support for a broad sectoral program. In general SWAPs also have a joint monitoring and evaluation plan.

The recent increase in high profile trusts and initiatives, such as the Global Alliance for Vaccines and Immunization and the embryonic Global Health Fund reflect a confluence of factors. First is the increasing focus upon meeting the needs of the poor (as discussed above), but there is also a sense of urgency and need to accelerate development efforts, combined with an increase in private benevolent foundations (such as Gates). While such trust funds represent considerable opportunities, it is also

conceivable that if not carefully managed they will undermine sustainable and systemic approaches to reaching the poor in favor of rapid, quick-fix solutions.

4.2 Key Recent Publications

Probably the most influential health systems publication since the time when the last PHR research agenda was drafted is the *World Health Report 2000*, which focuses upon improving health systems performance (WHO 2000). The WHR offered a new conceptual framework for thinking about health care systems that has stimulated substantial discussion. The report outlines four fundamental functions for health systems, namely service provision, resource generation, financing, and stewardship. More controversially, the report also identifies three health systems goals: good health, responsiveness to the expectations of the population, and fairness of financial contribution. The report does not identify research priorities but several “researchable” areas have emerged from the report and been the subject of extensive discussion.

First, the measures used to assess health system performance have been controversial, but the very attempt to measure performance has focused minds upon monitoring and evaluation issues and, in particular, the need to develop a better information base for understanding how alternative system designs affect performance. As stated in the WHR:

Knowledge of the determinants of health system performance, as distinct from the understanding of what determines health status, remains very limited. (WHO 2000 pp 44)

Subsequent to the publication of the WHR there have been numerous follow-up meetings focusing upon such measurement and evaluation issues. Such meetings have emphasized the need for stronger country-level monitoring, the need to better synchronize donor monitoring activity, the need to collaborate on the development of evidence bases, and the need to focus monitoring of interventions upon how they affect the poor.

Second, given the broader international aid policy environment described above it is not surprising that the WHR also had a strong focus upon the poor. The WHR states that the poor receive less responsive health care and often suffer as a consequence of regressive financing mechanisms.

The impact is most severe on the poor, who are driven deeper into poverty by lack of financial protection against ill health...the poor also emerge as receiving the worst levels of responsiveness – they are treated with less respect for their dignity, given less choice of service providers and offered lower quality amenities. (WHR 2000, pp xiv)

Third, the conceptual framework proposed by the WHR introduced two concepts that, while not entirely new, were rather unfamiliar. These were “responsiveness” and “stewardship.” The concept of responsiveness is supposed to cover those aspects of health service quality that do not contribute directly to improved health outcomes, such as treating patients with respect, giving patients choice of provider, and making the environment of a health care facility pleasant. There has been some debate as to whether this concept, as defined in the WHR, is a coherent one, but there seems to be a general agreement that such aspects are important.

The other newish concept discussed in the report is “stewardship,” defined as “the effective trusteeship of national health.” This is meant to encompass those government functions that contribute to ensuring that health care services are coordinated and operate in the interests of the community. Thus tasks such as policy making, regulation, etc. all fall within the stewardship function. The term stewardship also implies normative values: that “the pursuit of policy-making that is both ethical and efficient” and that government is “concerned about the trust and legitimacy with which its actions are viewed” (Saltman and Ferroussier-David 2000). In reality there is substantial evidence indicating that the poor commonly do not perceive government to be well intentioned (Narayan 2000), raising in turn the question of accountability mechanisms to encourage such behavior by government officials.

The final report of the Commission on Macroeconomics and Health (WHO 2001) echoes several of the themes of the WHR. The task of the CMH was to assess the ways in which expanded investment in health could contribute to economic development and poverty reduction. So it is not surprising that poverty, and the need to understand how health interventions affect the poor, feature strongly. While the report observes that the “lack of effective and capable health delivery systems” is a critical constraint to scaling up effective interventions, there is little discussion of health system strengthening per se.

Some of the more intriguing comments in the report are those concerning “categorical” (otherwise known as vertical) health care programs. Essentially the draft report states that, given capacity weaknesses in health care systems, maintaining and establishing categorical programs is a legitimate strategy, so long as it is complemented by attention to the broader, long-run constraints. The report also discusses some of the problems regarding corruption and motivation of public sector officials, suggesting that if senior health sector managers are not properly paid it is not surprising that health sector performance is poor.

For *PHRplus*, however probably the most interesting conclusion of the Commission regards community-based health insurance schemes:

The Commission recommends that out-of-pocket expenditures in poor communities should increasingly be channeled into “community financing” schemes to help cover the costs of community-based health delivery ... This method would offer a degree of risk spreading, so that households would not face financial catastrophe in the event of an adverse health shock to household income. (WHO 2001, pp 60-61)

While there has been increasing grassroots demand for assistance with the planning and implementation of such CBHI schemes, this is the first time that an international body has offered such an endorsement of this financing approach.

The CMH report also notes the need for stronger monitoring and evaluation. While the draft commission report noted that: “One of the dominant findings of the Commission’s work was the difficulty in obtaining evidence on the success or failure of most donor-supported programs. Simply put, they are not systematically evaluated.” (WHO 2001, draft). The final report toned down this conclusion but still observed the need for independent review and evaluation of donor-supported programs (WHO 2001, pp 97).

This conclusion probably draws upon the paper by Oliveira-Cruz et al. (2001) prepared for the CMH, which is concerned with establishing which approaches are effective at overcoming health systems constraints at the peripheral level. Oliveira-Cruz et al. found that for many interventions that

they considered, there was simply inadequate evidence to reach a conclusion as to whether this was an effective intervention. Based upon their findings the authors propose a research agenda (see Box 2).

Box 2: Gaps in our Understanding of Effective Health System Interventions*

- ▲ Decentralization: empirical studies of the impact of decentralization especially with respect to health outcomes
- ▲ The role of leadership in developing countries
- ▲ Impact of interventions upon the poor or disadvantaged
- ▲ The effectiveness of social marketing strategies
- ▲ The effectiveness of community financing strategies
- ▲ Role of incentives in improving performance
- ▲ Private sector delivery
- ▲ Interventions to address shortage and poor distribution of qualified staff
- ▲ Management strengthening
- ▲ Contracting
- ▲ Regulation of pharmaceutical and private sectors

Source: Oliveira-Cruz et al. 2001

* The topics listed in this box are somewhat selective. The authors list a large number of topics without always elaborating on exactly what is meant. The topics here are those that are given most space by the authors and therefore may be thought to be priorities.

There have been few high profile World Bank documents on health or health systems during the past few years; however, one that provides important insights, both into how the World Bank works and priority research areas, is a review of the Bank's own effectiveness in the health sector (Johnston and Stout 1999). The overarching recommendation of the report is that the Bank should "Do better, not more." This is linked to the finding that "Bank policy advice and reform strategy are too often insufficiently grounded in empirical evidence or institutional analysis of the country context" (p 28). The report also recognizes that for many of the reform areas in which the Bank is now working (such as health insurance reform, regulation of the private sector, health workforce reform) there are no generally accepted solutions. It is therefore recommended that incremental approaches to reform, such as pilots with evaluative research components, may be the most appropriate way to proceed. The report stresses the institutional challenges to effective health system strengthening and suggests that projects have not always paid adequate attention to implementation detail. For example, although Bank projects often assert that the poor should be protected from fee increases, it is rare that administratively feasible mechanisms are proposed. Similarly the Bank has advocated for resource reallocations to redress inequities but has rarely addressed the political dynamics that are the cause of such inequity. This broad theme of policy and implementation processes was one addressed by the PHR research agenda (Gilson 2001), but there is clearly much further work that could be done in this field.

The Johnston and Stout report highlights a number of areas that the authors perceive to be particular challenges for the future. Issues regarding the health work force feature heavily:

Bank training investments have also been consistently undermined by inadequate attention to the health labor market and performance incentives for providers in both the public and private sectors. Each of the country studies concluded that health work force issues are perhaps the most pressing challenge facing the respective health systems. (Johnston and Stout 1999, p 21)

While this statement is most likely true, in defense of Bank staff one could add that there is very little empirical information to guide policymakers and consultants in terms of how to structure appropriate incentives for health workers.

A further issue flagged by the report relates to regulation and the role of the private sector. The report notes that regulatory or quality assurance mechanisms for private providers in developing countries are weak to non-existent, despite the fact that private providers frequently represent a large proportion of the health sector contacts. There are difficult questions in devising regulatory strategies, particularly regarding appropriate roles for professional organizations. The report concludes on this topic that:

The challenge now is to build a solid empirical foundation on the optimal balance [between public and private sectors] in different country contexts, and the processes by which changes can be achieved. (Johnston and Stout 1999, p 24)

4.3 National and Regional Research Priorities

The documents described in Section 4.2 represent the view from the “global” level. In order to have a better sense of research priorities as perceived at the country level, *PHRplus* sought out country- and regional-level documents that sought to define research priorities. Very few of these exist. A paper prepared for a PAHO/WHO/IDRC meeting (PAHO/WHO/IDRC 2001) drew upon key informants in a number of different disciplines and provides a good review of current research and research priorities in the Latin American and Caribbean region. However no similar documents for other regions could be found. Emails were sent to the coordinators of a number of regional research networks.⁶ Responses were only received from two: the Health Economics and Policy Network (HEPNet), which covers East and Southern Africa, and the Asia-Pacific Health Economics Network (APHEN). The latter network is made up predominantly of health economists, and there is a clear bias to the disciplinary nature of the work perceived to be of priority.

A full summary of the research priorities identified by the PAHO/WHO/IDRC paper is included in Box 3. The report identifies three overarching themes, and then under each theme a number of specific topics. The themes themselves (particularly 1 and 3) echo many of the preoccupations at the global level.

⁶ The names of the networks and contact details of the coordinators were secured from International Alliance for Health System Research.

Box 3: Research Priorities for the Latin American and Caribbean Region

Theme 1: The role of the state, governance, and social participation

- ▲ State's functions and responsibilities in regulating the health system
- ▲ Managerial capacity, technical, and political viability of policy proposals
- ▲ Governance and the capacity to mediate interactions between stakeholders
- ▲ Relationships between the state and civil society, mechanisms for participation, legitimacy, and accountability
- ▲ The new institutional arrangements, the state regulatory function, and relationships between funding sources and health providers
- ▲ The stewardship role of health authorities

Theme 2: Challenges in the organization and management of health systems and health services

- ▲ Increasing importance of human resource management: impact of organizational changes, sectoral interests, new labor conditions, reorientation of human resources
- ▲ Analysis of decentralization: facilitating and obstructing factors in decentralization, local empowerment
- ▲ Evaluation of the separation of provision and purchasing functions
- ▲ Assessment of multiple and competitive health insurance schemes
- ▲ New challenges in service management, e.g., coordination at the system level of more autonomous organizations

Theme 3: Reform reorientation using health and equity criteria

- ▲ Improved methods to assess *system* effectiveness, particularly technical and perceived quality
- ▲ Innovative methods to widen social security coverage
- ▲ Impact of reforms upon different forms of equity
- ▲ Recovery and strengthening of essential public health functions
- ▲ Effective strategies to enhance intersectoral alliances and policies

Within Theme 1 the way in which the state relates to citizens within the health sector appears particularly important. The report notes that while substantial work has been done on investigating community participation at the service delivery level, very little work has investigated the role of the community at a higher level, for example, how they may contribute to overall political processes or strengthening mechanisms for legitimacy and accountability.

In terms of Theme 2 the human resource issues appear particularly pressing. The authors note that previously little attention had been paid to this area. Specific suggestions are made for research on the sociology of professions, and also exploring how recent trends in the organization of work

processes (such as the use of home care and day surgery) have affected the labor market. It is observed that decentralization has already attracted a substantial amount of research but, given the fact that this is the key policy reform in the region, much more remains to be done.

One interesting suggestion under Theme 3 is work on innovative methods to broaden social security health coverage. While the CMH report emphasized the role of community-based health insurance schemes in meeting the risk pooling needs of the poor and those outside formal sector employment, the well-established social security systems in the LAC region mean that this is a much more obvious strategy to try.

The reports from the coordinators of the two regional networks are not as sophisticated in terms of research priority setting. Table 4 summarizes priority topics for the two regions. In Southern and Eastern Africa, five countries (South Africa, Tanzania, Uganda, Zambia, and Zimbabwe) are involved in the network. Representatives from each country were asked to highlight the key policy issues in their country. The numbers in the table represent the number of countries (out of five) identifying this topic. For APHEN no similar discussion had been held. The numbers in the table represent the number of papers on this subject presented at the last APHEN forum.

Table 4: Summary of Research Priorities in Two Regions

HEPNet Southern and Eastern Africa	Asia-Pacific Health Economics Network
Human resource development and management (4)	Health care financing (insurance, equity, and NHA) (11)
Health care financing (user fees, social health insurance, and CBHI) (4)	Demand, patient behavior and expenses (7)
Decentralization (4)	Public-private mix and role of the private sector (6)
SWAPs (3)	Human resource issues (4)
Public-private mix (3)	Aging (2)
Hospital autonomy/efficiency (2)	Application of geographical information systems (2)
Resource allocation (2)	Poverty and health (1)
Restructuring the MOH (2)	

There seems to be considerable convergence within, and surprisingly across, regions. In both networks, studies of health care financing, human resources, and the public-private mix seem to be of importance. The limited emphasis on the poor is surprising, but it may be that this theme is embedded in some of the other issues (e.g., some of the health care financing issues).

4.4 Other Research Initiatives

It is important to have some understanding of the activities planned by other large research programs, partly as a guide to priorities, but more particularly in order to prevent overlap and duplication. This section covers ongoing or funded research that closely matches possible research interests of *PHRplus*.

The Department for International Development (DFID)-funded Health Systems Research Program identifies four broad areas of work (McPake 2001), namely:

- i. Choice, access, quality, and outcomes, with the aim of identifying practical strategies to ensure access for all to services of an acceptable quality
- ii. Redefining the role of government in complex health systems
- iii. Monitoring quality and impact
- iv. Effective intersectoral policies and programs

The proposal document provides a number of more specific research topics within these broad areas. It is not feasible to list all of these; instead we identify those that seem most similar to possible *PHRplus* research topics. Under the first research area the group suggests systematic reviews of existing qualitative and quantitative data sets to better understand patterns of health service utilization by the poor, as well as evaluation of strategies that attempt to improve services for the poor. The work on redefining the role of government suggests that a variety of studies might be undertaken looking at government provision, contracting, regulation, and various forms of public–private partnership. Research on different aspects of human resource policy including the education and retention of health workers is also suggested under this broad theme. In terms of monitoring quality and impact the group basically suggests the development and strengthening of monitoring methods at a variety of levels. A separate study examining the validity and relevance of WHR health system performance indicators is also proposed.

In some respects the World Bank Work Program on Health Systems Development bears greater resemblance to *PHRplus*'s Knowledge Building mandate: it is driven by operational concerns at the Bank and activities are frequently linked to World Bank supported interventions in the field. The Health Systems Development Work program suggests a number of topics where knowledge building, training, and advocacy will be combined. Box 4 summarizes the topics that the work program plans to address, distinguishing between those topics that will be approached in collaboration with other groups at the Bank, and those that the Health System Development program will address on their own.

Box 4: Topics to be Addressed by the World Bank Health System Development Program

Collaborative topics:

- ▲ Approaches to improving access by the poor to priority services: priority funding/purchasing of disease control programs, maternal health services, reproductive health services, nutrition services, and public health services
- ▲ Development of pro-poor intermediate indicators for achievement of international development goals
- ▲ Assessment of pro-poor Bank instruments

HSD-specific topics:

- ▲ Intermediate health systems performance indicators
- ▲ Public expenditure priority guidelines
- ▲ Human resources and public sector management
- ▲ Cost-effectiveness of specific disease interventions
- ▲ Pharmaceutical/vaccine production/pricing strategies

Plus continued work on:

- ▲ Financial protection for the informal sector
- ▲ Global health expenditure/NHA database
- ▲ Purchasing of health care services
- ▲ Organizational reform of service delivery (now with a focus upon the ambulatory level rather than hospitals)

In addition to the topics being addressed by the Health Systems Development work program at the Bank, other parts of the Bank are also undertaking research work that is very relevant to *PHRplus* interests. In particular a significant amount of work is being supported on evaluating the extent to which Bank programs and/or Bank-supported interventions are pro-poor⁷. Moreover the Bank has a longstanding research program examining issues of equity in health care financing and utilization⁸.

PHR and *PHRplus* have established good working relationships with the International Labor Organization (ILO) particularly in the West Africa region. The ILO is increasingly moving towards a focus upon those outside of formal sector employment and has recently initiated a review of alternative approaches to providing financial protection against health care costs for this group. The review examines social security, private insurance, and community-based schemes. While the initial

⁷ Personal communication Davidson Gwatkin.

⁸ Led by Adam Wagstaff.

stage of work focuses upon reviewing available literature and evidence, it is likely that future stages will include field-based research⁹.

WHO is the remaining organization that conducts substantial knowledge building activities in the area of health systems. Currently health system-related research seems to be scattered across a number of people/departments and (without visiting) it has been difficult to get a coherent and comprehensive picture of what is going on. It is certain that further work is now being conducted to refine the methods used to assess health systems performance, including more qualitative work on responsiveness. A recent workshop on “stewardship” within the health sector was held: we have not been able to find out what plans were made as a consequence of this. PHR exchanged ideas with WHO on health worker motivation and some limited WHO research is being pursued in this area.

⁹ Personal communication, Christian Baeza, ILO.

5. Selection of PHR*plus* Research Topics

5.1 Criteria for Selecting PHR*plus* Research Topics

A number of criteria were used in selecting PHR*plus* research topics:

- i. Research on the topic would be complementary to other PHR*plus* activities, for example, building upon technical assistance or special initiatives;
- ii. There is a strong demand for information on this topic;
- iii. The work would not duplicate that being conducted by other organizations;
- iv. It is technically feasible to conduct research that will make a real contribution to knowledge;
- v. Findings will be policy relevant: i.e., it will be feasible to take findings and apply them to policy making or technical assistance activities.

The first three criteria listed above correspond roughly to Sections 2-4 of this document. In terms of criterion III, the fact that another organization is undertaking research in a particular area does not automatically prevent PHR*plus* from pursuing a similar line of enquiry. Frequently researchers addressing a similar topic will bring very different conceptual frameworks and research methodologies. It is only if there appears to be overlap across these dimensions too, that the research is brought into question. Criteria (IV) and (V) are harder to make judgments about; whether or not studies meet these criteria depends a lot on the way that they are designed and implemented. The concept notes in Part 2 of this document begin to address some of these latter concerns in more detail.

5.2 Possible Knowledge Building Topics

From the review of ongoing activities within PHR*plus*, a number of themes emerge as being of importance. These include community-based health insurance, decentralization (including hospital autonomy), and regulation. The issue of improving accountability was not identified as a separate activity area but discussions with project staff that indicated that it was relevant to several of the activities being undertaken, including work on decentralization, hospital autonomy, regulation, and CBHI.

Responses to the surveys showed an overwhelming concern with access to health care services for the poor. But there was an (unsurprising) alignment between what mission staff and policymakers think it important for research to be conducted on, and the issues that PHR*plus* staff are actually working on in the field. Financing mechanisms (CBHI, social health insurance, and contracting) were perceived to be important, presumably because of the way in which they affect access for the poor, but also important were accountability, quality of care, use of information, and autonomous hospitals.

The international literature review confirmed many of the topics already identified but perhaps gave additional emphasis to human resource issues that seemed to be less highly ranked by the field. The PHR*plus* team also discussed the possibility of conducting research work on the concept of “responsiveness,” a concept that was presented in the WHR and around which there has been significant discussion.

Table 5 summarizes possible research topics emerging and the columns attempt to identify the priority that should be accorded to this topic, according to (i) how closely it links to PHR*plus* technical assistance, (ii) user demand and (iii) international interest and other work in this area. A final column notes any other relevant comments.

Table 5: Priorities across Possible Research Topics

Topic Area	Links to PHR<i>plus</i> Technical Assistance	User Demand	International Interest	Other Comments
Accountability	High (e.g., through hospital autonomy, regulation)	High	Emerging topic	Cross-cutting topic Strongly supported by TAG
Community-based health insurance	High	High	Very high	PHR reputation Strongly supported by TAG
Extending social health insurance	Moderate	High	High	Very similar work being implemented by ILO in LAC
Pro-poor policies	Moderate	High	Very high	Cross-cutting topic Substantial work planned by M&E team
Hospital autonomy	High	Moderate	Emerging focus on hospital policy	
Quality of care regulation	Moderate	Moderate	High to stewardship	
Responsiveness of services	Moderate	Low	High (WHR)	
Information use (e.g., by communities)	High	High	Moderate	Likely to occur as part of Intensive Research and Demonstration activities. Also substantial amount of work on this topic planned using SO5 funds.
Contracting and quality of care	Moderate	High	Moderate	Work plan of the Health Systems Development Group at the World Bank covers this.
Health worker motivation	Moderate	Moderate	Moderate	Builds upon research previously conducted under PHR. Interest from the field in certain dimensions e.g., handling motivational issues through reform processes such as decentralization.

The topics in bold in Table 5 indicate those that the Knowledge Building team ultimately selected to present to the Technical Advisory Group. Each of these topics is discussed in more detail in the concept notes in Part B of this document. This brief section discusses the principle reasons why the other topics were, at this point, rejected for further development.

Some of the topics identified in Table 5 were rejected as potential research topics to avoid duplication, as substantial work on these topics is already underway under other parts of *PHRplus*. For example the SO5 (Infectious Disease) team has planned substantial activities and research that look at information use and the development of an information culture. Work on pro-poor policies and assessment of the extent to which policies reach the poor is a focus of quite a lot of work planned by the M&E team. Moreover this was thought to be a cross-cutting issue, in the sense that several other research areas would, as part of the planned analysis, assess impact of the policy on the poor.

The one topic rejected specifically because it seemed to duplicate research work already underway is work on extending social health insurance. The Knowledge Building team discussed the possibility of conducting case studies of how social security schemes have tried to extend coverage to low-income people or people working in the informal sector. This ties in closely with many of the concerns mentioned by research users about access to health services for the poor, and may also offset an exclusive focus upon CBHI schemes as *the* strategy to risk pool for the poor. However the ILO apparently is already engaged in a very similar activity in the LAC region.

Quality of care issues were rated highly by research users. The Knowledge Building team considered for research¹⁰ three possible topics directly in the quality of care area, namely: regulation of quality of care, contracting for quality care, and the responsiveness of health care services. The notion of further work on responsiveness was rejected, as while it was thought that this was an important area for further conceptual development and qualitative research, the links to *PHRplus* technical assistance activities were weak, and the research appeared potentially academic. In terms of contracting for quality of care, *PHRplus* already had ongoing a small-scale study on this topic that look at the approaches used by mutuelles to including quality in contracts (a preliminary report is now available, see Quijada and Kelley 2002). It was thought advisable to await findings from this study before proceeding further. In addition, this is one of the topics covered by the World Bank Health Systems Development team's work program. Ultimately work on regulation of quality of care was chosen as the primary focus for quality on the Knowledge Building agenda.

Four of the topics selected represent different aspects of the health care system, including financing (CBHI), health system organization (hospital autonomy), policy and the role of government (regulation), and human resources (health worker motivation). Accountability is viewed as a cross-cutting topic that affects each of the areas identified above. While the issue of "pro-poor" policies is not represented in a distinct concept paper below, it is also clearly directly relevant to several of the topics listed above (and other work undertaken by *PHRplus*) and researchers will try to weave it into study protocols where relevant.

¹⁰ Health worker motivation also clearly affects quality of care, although motivational issues are also likely to have other effects too.

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Part 2: Concept Notes

1. Approaches to Strengthening Accountability within Health Systems

Derick W. Brinkerhoff

Background

Around the world governments face pressures to provide health services effectively, efficiently, and equitably. Reform and strengthening efforts in industrialized and developing/transitioning countries have adopted similar approaches to getting health systems to perform better: downsizing, privatization, partnerships, competition in service delivery, performance measurement and indicators, and citizen participation. All these approaches converge in emphasizing accountability as a core element in implementing health reform and improving system performance.

The current concern with accountability and health systems reflects several factors. First is dissatisfaction with health system performance. In industrialized countries, this has centered on cost issues, quality assurance, and access. In developing/transitioning countries, discontent has focused on these same issues, plus availability and equitable distribution of basic services, abuses of power, financial mismanagement and corruption, and lack of responsiveness. Policymakers and citizens want health care providers to exercise their responsibilities professionally and correctly according to regulations and norms, and with respect for patients. Second, accountability has taken on a high degree of importance because the specialized knowledge requirements, along with the size and scope of health care bureaucracies in both the public and private sectors, accord health system actors significant power to affect people's lives and well-being. Further, health care constitutes a major budgetary expenditure in all countries, and proper accounting for the use of these funds is a high priority.

Thus, there is a consensus that health care provision needs to improve, that the power of health care providers should be circumscribed, that their actions should be exercised subject to some form of oversight, and that resources need to be properly tracked and utilized. These put accountability front and center on the stage of current health system improvements. Better accountability is seen as imposing restraints on power and authority, creating incentives for appropriate behaviors and actions, and enhancing system outputs and results.

Current State of Knowledge

Accountability is one of those terms that appear frequently in speeches by politicians, chief executives, and citizen activists. This popularity is a plus for system reform because it can help to mobilize demand for change. Experience with policy reform, documented by PHR (e.g., Gilson 1997, Gilson et al. 1999) and other USAID-funded analyses (Brinkerhoff 2001a), shows that demand-driven reforms are more successful and sustainable. However, as a guide to the specifics of what to do

to improve health systems, simply calling for more accountability is less helpful. On the surface, the idea of checks and restraints on power and discretion seems straightforward, but in order for accountability to inform action, further conceptual and operational work needs to be done.

The literature notes the problems with the lack of definition and operationalization. For example, Mulgan (2000: 555) calls accountability a “complex and chameleon-like term.” As Schedler (1999: 13) notes, “accountability represents an underexplored concept whose meaning remains evasive, whose boundaries are fuzzy, and whose internal structure is confusing.” General definitions of accountability include the obligation of individuals or agencies to provide information about, and/or justification for, their actions to other actors. Specific issues arise regarding accountability for what, to whom, with what result? Enforcement mechanisms are critical, from broad legal and regulatory frameworks to internal agency monitoring systems. A lively debate regarding enforcement concerns the extent to which service delivery markets can be created such that accountability is automatically enforced when poor quality providers are eliminated as purchasers select higher quality, more entrepreneurial providers.¹¹

The literature related to accountability is vast, but not very integrated. Three general categories can be identified (see Brinkerhoff 2001b). The first addresses the most commonly understood notion of accountability, and concerns financial accountability. This literature deals with compliance with laws, rules, and regulations regarding financial control and management; and discusses approaches, systems, and tools for auditing, budgeting, and accounting. The second category of literature looks at accountability for performance. It is arguably the largest, encompassing the huge literature on public sector management reform, performance measurement and evaluation, and service delivery improvement.¹² The third category focuses on political/democratic accountability. Literature here ranges from theoretical and philosophical treatises on the relationship between the state and the citizen, to discussions of increased citizen participation, equity issues, transparency and openness, responsiveness, and trust-building.

Within the health sector, each of these three categories of literature is well represented, although with more breadth and depth related to experience in industrialized countries than in developing and transitioning ones. It is important to note that although the health reform and system strengthening literature can be grouped into these three categories, accountability tends not to be the organizing theme for most individual sources. Rather, analyses focus on one or another aspect of health system reform, and treat accountability (if mentioned at all) as a secondary or corollary dimension. For example, there is a large literature on community participation in health services reform and delivery, some of which notes that among the rationales for, and results of, community participation is increased targeting of services on community needs and more accountability (see, for example, Cornwall et al. 2000). Another topic area where accountability issues are mentioned concerns health system governance and institutional structures: for example, national, district, and local health boards;

¹¹ In the governance literature, this debate is reflected in a concern that market mechanisms transform citizens into consumers. When service providers are responsive only to citizen-consumers who “vote” with their dollars, what happens to accountability to those with limited purchasing power? See Blanchard et al. (1997). Regarding the role of markets and the private sector in the health sector, the literature is extensive. See, for example, Appleby (1999) and Enthoven (1999) on the UK’s National Health Service. See Bennett et al. (1997) on private provision of services in the developing world.

¹² These reforms consist of a loosely bundled set of concepts drawn from the pioneering administrative change efforts in Australia, New Zealand, and the United Kingdom (the New Public Management), and later from the United States (the Reinventing Government movement). For an analytic overview of the New Public Management, see Ferlie et al. (1996). On Reinventing Government, see Osborne and Gaebler (1992) and NPR (1996). Regarding the application of the New Public Management in developing countries, see, for example, Polidano (1999).

hospital boards; medical review boards and professional certification bodies; decentralization; and so on (see, for example, Savage et al. 1997, NPPHCN 1998, Mills 1994). In the health economics and financing literature, as noted above, accountability implications can be identified in the context of analyses of health care markets, principal-agent issues arising from information asymmetries, public-private mix, demand-driven services and user fees, priority-setting, and separation of payment from provision.¹³ Accountability also figures, sometimes implicitly, sometimes explicitly in the quality assurance/quality improvement literature.¹⁴

Arguments for PHR*plus* Research on Accountability

Accountability warrants research attention for a number of reasons:

High profile. Strengthened accountability is widely called for as a remedy for health system failings around the world. Donors and reformers alike discuss accountability issues from a number of perspectives in discussions of health reform. Given this high profile, it is worthwhile for PHR*plus* and USAID to develop a sharper understanding of accountability.

Lack of conceptual and empirical integration. Increased accountability is sometimes advocated with little understanding of what it would take to design or implement effective measures, or of what the trade-offs might be. In other cases, there are so many public agencies with oversight responsibility and private entities undertaking review and/or accreditation that duplication of effort and gaps coexist. Without sounder conceptual frameworks and more empirically based recommendations, accountability risks becoming yet another buzzword in a long line of ineffectual quick fixes, or, worse, a one-size-fits-all bludgeon that encourages excess and overregulation.

Potential for improving health sector strengthening. Focusing on accountability can: (i) help to generate a system-wide perspective on health sector reform, and (ii) identify spread and multiplier effects among particular interventions. These results can support synergistic outcomes, enhance system performance, and contribute to sustainability. A sharpened focus on accountability can help identify gaps in strengthening efforts and broader environmental constraints that extend beyond the health sector. For example, citizen involvement in health sector oversight depends upon the availability of information, both budget and performance; thus the degree of government transparency will be important.

Research Questions

At this point, although it is premature to specify detailed research questions, a two-pronged research strategy is proposed. The first prong would be to prepare a background paper addressing some broad areas of investigation, which could include the following types of questions:

- ▲ Definition and clarification of accountability. How can the term be more usefully defined and made more operationally relevant?
- ▲ Role of health sector actors in accountability. Who are the accountability actors in the health system? What are the roles of policymakers, service providers, financing bodies, the

¹³ See, for example, the various chapters in Janovsky (1995). Numerous PHR documents cover these topics; see, for example, the list of applied research reports available at <www.PHRproject.com>.

¹⁴ See, for example, the materials developed by the USAID-funded Quality Assurance Project.

private sector, civil society with regard to accountability?

- ▲ System-strengthening strategies. How can accountability be improved? What strategies lead to which outcomes? What are the trade-offs? Capacity issues?
- ▲ Standards, targets, and measurement. What are appropriate standards, and targets for which actors should be held accountable? What steps are feasible? Who should be involved?

The second prong would search for field opportunities to pursue investigation on operational issues where accountability concerns are prominent, and where possible links would be made with other research themes. There are evident links between this topic and hospital autonomy, quality of care regulation, and CBHI. For example operational research on accountability could focus on institutional structures for health system governance, such as autonomous hospitals. What kinds of governance structures have been put in place, and at what levels? How have these functioned in practice? What sorts of accountability mechanisms and processes have they employed? What roles can communities play? What results have been achieved? What tradeoffs arise?

Next Steps in Developing this Research Area

The following next steps are proposed to pursue the research strategy. These steps would be parallel, rather than sequential:

- ▲ Develop a background paper that reviews and synthesizes the accountability literature with a focus on the health sector.
- ▲ Canvass USAID missions for interest in dealing with accountability issues. Some initial interest has already been expressed.
- ▲ Identify opportunities in PHR*plus* field sites for operational research on several specific topics (e.g., hospital governance, regulation) that could be pursued in the context of technical assistance activities.

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2. The Equity and Sustainability of Community-Based Health Insurance as Part of National Health Financing Structures

Sara Bennett and Charlotte Leighton

Background

Since the mid-1990s there has been increasing interest in community-based health insurance schemes. Several national governments, particularly in sub-Saharan Africa have started to explore this option as a means to enhance the financial accessibility of services while maintaining some form of cost sharing. In many countries (such as Ghana and Tanzania) CBHI schemes complement extensive public health service networks that are largely government financed. From the perspective of international organizations and donors, CBHI is also a promising mechanism: it has been touted as a way to respond to the needs of the poor, an issue that is very much at the front of such agencies agendas at the current time. However there is very little empirical evidence to support or refute these claims.

For the purposes of PHR*plus* research we will define a CBHI scheme to be: any scheme managed and operated by an organization other than government or a private for-profit corporation, that provides some form of risk pooling to cover the costs (or part thereof) of health care services. The schemes should be voluntary in nature: properly mandatory schemes are rare and in form are very similar to government taxation. The insurance fund could be managed by a variety of organizations (mutuelle, facility, community-based organization) and could cover a variety of benefit packages.

Current State of Knowledge

There is a burgeoning literature on CBHI schemes. Until the mid-1990s virtually all studies of CBHI schemes consisted of single scheme analyses providing overviews of a particular scheme¹⁵ (Moens 1990) or analyzing a particular aspect of a scheme (such as willingness to pay for the membership (Arhin 1994) or equity in geographical access (Criel 1992)). Two publications by PHR*plus* staff (Bennett et al. 1998, Atim 1998) at the end of the 1990s began to synthesize lessons across schemes but were constrained by the data available in terms of the rigor of cross-country analyses. General conclusions coming from these reviews were that many problems had arisen due to

¹⁵ Stinson 1983 is a notable exception to this, providing an early review of the potential contribution of a wide variety of forms of community financing.

basic design flaws in the schemes. While many schemes reviewed had limited membership and limited lifespans, it was impossible from the evidence base available to conclude how successful well designed schemes might be. During the past five years considerable efforts by international agencies and projects such as PHR have been undertaken to strengthen the design and implementation of CBHI schemes.

Much of the available data on schemes is taken from routine information systems and is often patchy and somewhat unreliable. While some studies of schemes have undertaken special studies, very few have been fortunate enough to have established proper evaluative designs in advance. One notable exception is the evaluative work conducted in association with the CBHI scheme initiated in Rwanda under PHR (see Schneider et al. 2001). The study clearly showed increased utilization amongst scheme members. Data collection, however, occurred just one year after the start-up of the scheme when there were still very low membership rates: it is unclear how robust these findings are.

During the past year, two further initiatives to research CBHI were implemented. First, Working Group 3 of the Commission on Macroeconomics and Health commissioned a series of reviews as well as undertook a meta-analysis of existing data sets (Hsiao 2001, Arhin-Tenkorang 2001, Preker et al. 2001). The synthesis paper on this topic is fairly upbeat, suggesting that such schemes are a viable means to extend financial protection against the costs of health care to the poor. However no new studies were undertaken as part of the Working Group's work and hence this finding is also made upon the basis of limited empirical evidence.

The second initiative is the development of an edited volume on reinsurance of CBHI schemes that was jointly undertaken by the ILO and the World Bank (Dror and Preker forthcoming). The (implicit) starting point for this volume is that one of the core reasons for lack of financial sustainability of CBHI schemes is their small size and inability to absorb risk. Reinsurance is proposed as a mechanism through which to rectify this problem. While the need for reinsurance is a logical assumption, it is far from self-evident that reinsurable risks form the major problem for scheme sustainability. Again this volume does not present new data but rather uses experience from industrialized countries to propose how reinsurance schemes might work, complemented by anecdotal evidence from the developing world.

Arguments for PHRplus Research on CBHI

High profile of topic: as demonstrated by the amount of work produced on this topic during the past year, CBHI is an extremely high profile issue at this point. The CMH report recommends that donors financially support CBHI initiatives. The ILO has recently started an internal review process with the aim of defining its own position on these schemes. It is possible that the ILO review will be followed by a more substantial investment by ILO in research in this area¹⁶. The World Bank, together with the WHO has recently secured funding from IDRC to support research in this area. One danger in PHR engaging in research in this area is that our efforts may later be overshadowed by better funded research projects. However if we continue to maintain close coordination with other agencies interested in this area then we may have an opportunity to feed into and inform any subsequent initiatives.

¹⁶ Personal communication, Christian Baeza, ILO.

Need for more empirical evidence: the summary of the state of knowledge above emphasized the lack of empirical data. The World Bank's health system development workplan noted of this area that "it is an area in which we need to be able to give much better informed advice to our clients."

PHRplus track record in this area: PHRplus has a substantial volume of work in this area. The West Africa region, and in particular Ghana, is engaged in some highly innovative developments. Predecessor projects (PHR and Health Financing and Sustainability) contributed substantially to the literature in this field. It is undoubtedly an area where PHRplus has acknowledged expertise.

Opportunities to build upon technical assistance activities: PHRplus is engaged in work on this topic area in Senegal, Ghana, Mali, and Tanzania. Ghana and Mali may provide particularly interesting opportunities to build research upon technical assistance activities. In Ghana there is interest in the development of social reinsurance initiatives in the Ashanti region. In Mali, PHRplus will be providing technical assistance to help with the formation of new mutuelles. PHR formerly undertook a household survey exploring health service utilization and expenditures in this same region, which may form a suitable baseline study.

Research Questions

An initial brainstorming by PHRplus staff identified three possible foci for research:

Equity and Poverty and CBHI

CBHI schemes have frequently been touted as a means to "serve the needs of the poor." However the empirical data available seem to suggest that in general it is the rural middle class that makes up most of the membership of such schemes. PHRplus research in this area could address this fundamental question answering questions such as:

- ▲ Which income groups are most likely to join CBHI schemes?
- ▲ How does the presence of a CBHI scheme in a community affect utilization of services by different income groups (and by members/non-members)?
- ▲ To what extent do CBHI schemes reduce the financial vulnerability of member households?

Most of these questions would be quite straightforward to address if household survey data including variables on scheme membership were available. Mali may be a particularly good site for PHRplus to address these questions but it is possible that data sets from other countries might also be available.

This line of enquiry could be further enriched if it were possible to institute innovative mechanisms to protect the poor in different CBHI schemes and to use the questions above (amongst others) to evaluate such mechanisms. Possible mechanisms that could be tested include: sliding scale of premiums, use of government subsidies to exempt the poor from premiums, lower co-payments for the poor. Testing such mechanisms would also require data on the feasibility and cost of implementing the mechanism.

Risk and the financial sustainability of CBHI schemes

Reviews of CBHI schemes have highlighted the fact that, while some schemes have existed many years, the majority have very short lifespans. A key concern around the promotion of CBHI

schemes as a health financing strategy is their financial sustainability. It seems likely that much of the work on reinsurance was initiated under the premise that small risk pools combined with the lack of opportunity to reinsure was the fundamental obstacle to financial sustainability. However there is no empirical evidence on what the main sources of risk facing CBHI schemes are. Theory and experience suggests that CBHI schemes face a number of different types of risks including:

- ▲ Reinsurable risks: random shocks due (for example) to epidemics, macroeconomic shocks.
- ▲ Issues in risk pool management such as small risk pools, or risk pools containing a high proportion of high risk people. These problems may be associated with failure of certain risk management mechanisms such as ensuring that whole households join a scheme, or the enforcement of a waiting period after enrollment.
- ▲ Management failures including failure to collect all premiums, failure to define and implement a benefit package, failure to shepherd fund resources.

PHR*plus* could contribute to understanding of issues affecting financial sustainability by developing indicators to measure these different sources of risk, applying these indicators to a sample of CBHI schemes, and, over time, tracking how well these different risk indicators explain the financial performance of schemes. It may be possible to undertake this research in association with the proposed reinsurance scheme in Ashanti.

CBHI and the broader financing context

Underlying both of the issues identified above is the question of how CBHI schemes interact with the broader health care financing framework. As noted earlier, it is commonly the case that CBHI schemes are developed in contexts where there is also substantial government financing of health care services. In some instances CBHI schemes facilitate access to private providers that are perceived to offer higher quality care. In others, however, they simply provide risk pooling for the cost sharing element of government services. In some cases (as with the Community Health Fund in Tanzania) the government provides an additional government subsidy direct to the scheme.

Understanding the broader health care financing context is important when assessing equity or financial sustainability issues. For example schemes may not be successful at encouraging the poorest members of a community to join, but if there are effective government-financed safety nets to cover care for this group, then this may not be problematic. Conversely, if CBHI schemes become the primary mechanism for financing health care for poor rural communities, while government focuses its subsidies on more affluent urban groups, then this may be very problematic. Similarly, problems of risk pool management are likely to be much reduced if government fully finances secondary and tertiary services, while CBHI schemes focus upon primary care.

PHR*plus* research in this area could, first, develop a series of models that map the role of CBHI schemes with respect to the broader health care financing system. These models could then form the basis for empirical work that would measure the amount of funding flowing through different channels. Secondly, improved tools for monitoring the contribution that CBHI schemes make to overall government objectives are required. Although several handbooks (e.g., Cripps et al. 2000) set out guidance regarding monitoring of individual schemes, there is currently nothing that addresses how governments should monitor the overall impact of such schemes.

The discussion above has identified a number of specific research issues:

- i. Analysis of the effects of CBHI schemes by income group (membership, service utilization, financial vulnerability) (potentially using Mali data);
- ii. Experimentation with alternative approaches to protect the poor through CBHI schemes;
- iii. Analysis of alternative sources of financial risk facing CBHI schemes;
- iv. Mapping of how CBHI schemes fit into the broader health care financing system and the implication of alternative models for overall equity and sustainability;
- v. Tools for monitoring the role that CBHI schemes play from a national/government perspective.

Next Steps in Developing this Research Area

Progress with several of the research issues identified above, particularly (i) and (ii) is contingent upon developments in the field. The Knowledge Building team will continue to collaborate closely with field staff working on these issues to identify and promote research opportunities.

For issues (iii)-(v) considerable conceptual work needs to be completed. Accordingly PHR_{plus} will initiate brief conceptual papers on each of these topics and the development of tools to support empirical measurement in these areas. As these concepts and tools are developed, the Knowledge Building team will seek opportunities to apply them in the field. If thought desirable a regional workshop in West Africa will be held at the end of 2002 to present the tools and discuss their practical application.

Close coordination with the international organizations conducting research in this area will be maintained.

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3. Hospital Autonomy

Mary Paterson

Background

The concept of autonomous public hospitals has been discussed in the development literature since the early 1990s. This concept has been of interest because of the significant share of developing countries resources that are allocated to public hospitals. If public hospitals could be made more accountable for the public funds allocated to them, and also be empowered to raise additional revenue, it was thought that the pressure on public health care budgets would be reduced. Additionally, it was hypothesized that autonomous public hospitals would be more efficient and responsive to end-users, since they would be increasingly responsible for their own fate (Govindaraj and Chawla 1996: 1-64).

The conceptual frameworks underlying public hospital autonomy in the developing world are not well developed. Barnum and Kutzin presented a thorough description of the placement of public hospitals in the health systems of developing countries in 1993. Subsequent discussions of public hospital autonomy in the developing world tended to focus on the activities needed to strengthen public hospital financial and management policies as well as procedures and practices that prepare such hospitals for autonomous roles. Studies of the public hospital sector in the developed world provide a more fully developed set of conceptual frameworks. In particular, the study of public sector rural hospitals in the United States provides an useful set of concepts that can be used to classify the existing work on public hospital autonomy as well as to identify gaps in the current knowledge of public hospitals in the developing world (Seavey et al. 1992).

Conceptual Framework

Two general concepts have been used effectively to understand the situation of public hospitals that exist in resource scarce environments: strategic management and population ecology. Strategic management encompasses a wide variety of constructs that describe the methods used by an organization to acquire the resources needed for organizational survival. The strategic management concept suggests that an organization is pro-active in search of these resources, and seeks to acquire them from the surrounding environment. A useful distinction has been made between organizations that must acquire resources on the basis of technical services as opposed to those that acquire resources based on institutional placement in the environment. For example, a fire department might survive because it provides an essential community service niche in the environment and is provided with resources to enable it to occupy this niche. An auto mechanic might gain resources from the environment by offering technically superior services of higher quality and efficiency than similar organizations. Research on the hospital environment suggests that in the United States, public hospitals have moved from an institutional placement to a provider of technical services in a

competitive environment (Alexander and D'Aunno 1990). As a result public hospitals are held to a technical standard of efficiency and effectiveness.

Population ecology models suggest that organizational survival is dependent on a set of environmental constructs that either support or eliminate certain organizational forms. In this framework, the capacity of public hospital management to adapt is bounded by the environmental niche in which they are placed. For example, carrying capacity (the minimum population needed to support a public hospital) is a limiting factor that skillful and adaptive management cannot overcome. The population ecology model suggests that skillful managers leave organizations that are placed in non-supportive environments. Given this perspective, social policies that impact the public hospital environment are important determining factors for public hospital survival. If social policy creates conditions not supportive of public hospitals, expert strategic management capacity may not exist, and would be of limited value to institutional survival.

Current State of Knowledge

In the development literature, much of the emphasis has been placed on the public hospital as a technical organization that must improve its efficiency and effectiveness. The focus of this literature has been on the hospital's ability to use the strategic management model to effect these improvements, improve operations, and survive. Barnum and Kutzin suggest four key issues that should be considered: resource dependency or the share of public resources absorbed by hospitals, hospital costs and productivity, the feasibility of cost-recovery, and the optimal use of referrals to assure appropriate care delivery. The focus of this useful discussion is the hospital as a technical organization that must deploy its resources in the most efficient and effective way possible. Barnum and Kutzin further suggest that the public hospital should respond to the larger public policy goal of maximal health for the population, and that use of the hospital should be appropriately targeted to achieve this goal.

Rukmono, Sardadi, and Budihartono in their study of public hospitals in Indonesia (1990) identify environmental characteristics as limiting factors that impact effective strategic management. For example, they note that the technical efficiency of teaching hospitals is adversely impacted by the public policy goal of educating health care providers. They also identify the political forces in the environment and state that policies, strategies, and decisions regarding public hospitals are heavily influenced by the local government and the regional and local health office. Given the recognition of these environmental factors, it is interesting to note that strategies to improve the technical effectiveness of the public hospital were recommended, rather than public policy strategies that might rationalize conflicting public policy goals and create a more supportive environment for the public hospital and support strategic management efforts.

Walford and Grant in their study of improving hospital efficiency (1998) suggest that focusing on the hospital as a technical organization, and aligning strategic management practices in support of efficiency and effectiveness can yield enormous efficiency gains. They also suggest consideration of the environment surrounding public hospitals in the context of the willingness to take difficult decisions on public hospital closure, and assess likely demand for hospital services and availability of resources to pay for care. The major focus of the work, however, remains strategic management and technical efficiency within the public hospital itself.

The Data for Decision Making project provided a robust conceptual framework and evaluation guidelines for hospital autonomy (1996) that was based on strategic management and technical efficiency constructs (Chawla, Berman and Govindaraj et al. 1996). The definition of hospital

autonomy offered by the authors included all hospitals rather than just public sector hospitals and suggested that two dimensions should be included: the extent of centralization of hospital decision-making, and the range of policy and management decisions relevant to hospitals. These dimensions recognize the existence of not only strategic management, but also the environment surrounding the hospital. This is further expanded by the definition of two domains for decision-making; the health domain, which includes macro-level decisions about the sector, and the hospital domain, which includes decisions normally considered a part of strategic management. The evaluation framework proposed for hospital autonomy also includes a suggestion that the environmental context in which hospital autonomy takes place should be considered as a factor in evaluation and further suggests community involvement and accountability as constructs useful in evaluating the impact of hospital autonomy. However, the focus of the evaluation questions was on the activities of the hospital managers themselves, rather than on the activities of the public policymakers in the environment surrounding the hospital. The implication in this model is that the environment is a mutable variable that can be made supportive by activities of the hospital management itself.

The Data for Decision Making project provided a very useful evaluation of hospital autonomy programs in India, Zimbabwe, Kenya, Ghana, and Indonesia (Chawla et al. 1996). This evaluative study was based on in-depth case studies of the five countries and concluded that autonomy in public sector hospitals has not yielded many of the hoped-for benefits in terms of efficiency, quality of care, and public accountability. They further suggest that a flawed conceptual basis for hospital autonomy measures is as responsible as poor implementation for the failure to produce results in the countries studied. One important conclusion in this study was the recognition that public hospitals function both as business entities and as public policy instruments. Therefore, these hospitals have an obligation to serve national policy objectives and social goals. These findings suggest that the use of the strategic management conceptual model and the emphasis on technical efficiency may have limitations when public hospitals are considered.

Arguments for PHR*plus* Research on Hospital Autonomy

Significance of the topic in health systems development: Building and running hospitals absorbs the major share of health expenditure in any country. In developing countries that are subject to increasing fiscal pressure, the cost of maintaining a public hospital system may tax limited health care budgets, and decrease funds available for cost-effective primary and preventive care targeted to vulnerable populations. The current strategy of targeting primary care services for improvement will not yield long-term gains if public hospitals are not also strengthened, since hospitals provide acute referral services as well as care for the chronically ill.

Need for more robust models, intervention methods, and evaluation strategies: The previous discussion demonstrates that the emphasis on the strategic management and technical efficiency may be necessary, but not sufficient to improve public hospitals in developing countries. Because public hospitals are also agents that implement social goals and national policy objectives, it is important to provide models that re-integrate policymakers and communities into the hospital autonomy agenda and educate key stakeholders in the use of such models. Development of these tools will be particularly important given the focus on poverty alleviation and targeting of health benefits to the poorest segment of society since this population is, in some contexts, heavily dependent upon public hospitals.

Lack of conceptual and empirical integration: Current and proposed PHR*plus* work in hospital autonomy is focused on strategic management and technical efficiency. This focus may be a necessary first step in many countries since this type of strategy is an obvious solution to public

hospital inefficiency. In time however, extension of the empirical work, based on more clearly defined conceptual frameworks, may be possible. The opportunity to expand the current hospital autonomy interventions to encompass a broader policy agenda is important and could provide an alternative field-tested model for use in the wider development community.

Research Questions

Research in this area needs to provide a more solid base for hospital autonomy work in the development context. Several activities are suggested that can complement existing *PHRplus* implementation activities.

- ▲ Provide a more developed model, based on population ecology organizational frameworks, that supports development of public policy and community interventions supportive of public hospitals in the developing world. This model would review existing literature on the application of population ecology models to public hospitals in the developed world, and derive a strategy and suggested implementation steps for use in the development context. The model would include an assessment tool, implementation steps, and an evaluation strategy that could be used to assess important characteristics of the public hospital environment and implement strategies to improve the environment, and an evaluation of the results of the intervention.
- ▲ Test the model in at least one *PHRplus* country interested in public hospital improvement. Currently three countries are active in this area: Jordan, Malawi, and Eritrea.
- ▲ Disseminate the model and findings to the country and the development community through a technical report and publication in a refereed journal.

Next Steps in Developing This Research Area

- ▲ Develop a technical direction that would provide the resources needed to adapt the population ecology model to the development context and produce a public hospital environmental assessment tool, suggested implementation strategies, and evaluations tools that could be field tested.¹⁷
- ▲ Discuss field testing of the tool with the three countries currently involved in hospital autonomy work, and select the best candidate country for the field test.
- ▲ Introduce the tool and model to key stakeholders in the selected country through a small workshop.
- ▲ Field test the tool in the selected country. Funding for this work could be shared with the local USAID mission.
- ▲ Based on the assessment, recommend an implementation plan that focuses on the community and policy environment surrounding the public hospital.

¹⁷ The tool used in the study of small rural hospital in the United States is available and could be evaluated for use in the development context.

- ▲ Gain approval for implementation of the recommended strategy.
- ▲ Implement the plan using mission support.
- ▲ Evaluate the results.
- ▲ Prepare and disseminate a technical report and journal article on the results.

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4. Regulation and the Quality of Private Health Care Providers in developing Countries

Nadwa Rafeh and Sara Bennett

Background

Health sector regulation has emerged as a key issue in developing countries in the past decade. This is mainly due to the growing role of the private sector in developing countries and the inability of governments to organize and control newly emerging health care markets. There is substantial evidence to suggest that quality of care among unregulated private sector providers can be poor, and occasionally dangerous (Brugha and Zwi 1998). Added impetus has been given to the focus on regulation by various attempts to re-think an appropriate role for government. Influential documents such as the *World Health Report* (2000) advocate that governments should “row less and steer more,” suggesting that governments should devote less energy to the direct provision of services and more to ensuring that the sector overall works to improve the welfare of citizens. Regulation is commonly viewed as a core stewardship function that helps the government ensure positive outcomes for the sector.

Today, many developing countries engaged in health sector reform initiatives are targeting regulatory system strengthening as a key reform objective. However, little is known about successful design and implementation of regulatory policies in developing countries. This research aims to study regulation in developing countries and determine the factors that contribute to successful implementation of regulation. More specifically, this research will examine the role of regulation in improving the quality of health care services in the private sector.

In this context, regulation is defined as a set of influences exerted by an external authority aimed at changing behaviors within provider organizations to improve quality of care (Institute of Medicine 2000). This *PHRplus* research is based on the assumption that, when properly aligned, external regulatory influences exerted by capable external institutions, can lead to internal provider behaviors conducive to quality care. However, in practice, there are a number of reasons why regulatory implementation fails to achieve its goals. The research described here aims to map out the reasons for regulatory failure and assess alternative strategies for strengthening the implementation of regulation.

Current State of Knowledge

The debate over the use of regulation as a reliable strategy for improving the quality of care has been going on for some time. While some disagree with the use of regulation as a strategy to improve quality of care, many still consider regulation to be the only available mechanism that safeguards the public from poor quality (Chassin 1998).

Those who argue in favor of regulation often consider it a way to address the many problems that arise in the production, financing, and delivery of health care in the private sector (Kumaranayake, 1998). More specifically, regulation is seen as a legal influence capable of controlling the entry and exit to the health care market, controlling competitive practices and remuneration, setting minimum standards of care, and ensuring safety and quality of the health care system.

Concerns about the use of regulation to improve the quality of care are based on the fact that, if not properly designed, regulation can lead to negative provider behavior, thus obstructing what regulation is designed to promote. In a study that analyzed variation in hospital mortality among Medicare patients it was shown that hospitals operating in highly regulated states had higher mortality rates than hospitals operating in states with less regulatory stringency (Shortell and Hughes 1988). Under the Medicare prospective payment system, hospitals were less likely to admit beneficiaries with high costs, and they also reduced use of therapeutic and diagnostic resources, and lengths of stay (Lohr 1985). Literature on cost regulation shows that, when financial pressures are exerted on providers, or when health facilities are faced with external pressures to reduce costs, they may allocate resources in ways that have a negative impact on patient care. Strict regulatory constraints such as setting hospital rates or granting certificates of need are likely to act as barriers to innovative services that may improve the quality of care (Morrisey et al. 1983, Dranove and Cone et al. 1985).

While there is extensive literature that documents the impact of different kinds of regulatory measures on provider behavior, the vast majority of this literature originates from industrialized countries. It is difficult to draw lessons from such studies for developing countries given the substantial differences in context. In particular lack of government capacity to implement regulation in developing countries may be an especially pressing concern (Mills et al. 2000). There is some literature examining the use of licensing of professionals and accreditation of facilities as means to improve the quality of care in developing countries. Results on licensing (both from developing and industrialized contexts) show that licensing alone is not an adequate mechanism to ensure quality of care (Gaumer 1984, Yesudian 1993). Among the main reasons for the failure of licensure to ensure quality is lack of enforcement due to lack of resources, or due to conflict of interest among professional organizations that are usually charged with professional licensing and their reluctance to operate against their own members (Bennett et al. 1994). In this case, self-regulation by medical professions is an important factor that deserves further analysis.

Lately, there have been numerous efforts by donor organizations, such as the WHO and World Bank, to further explore the issue of regulation. The World Bank, in its latest module on “Harnessing private participation in the health sector through active regulation” provides an overview of health sector regulation, its different forms and institutional structures, but only concludes with some practical considerations for operationalizing regulation. More practical evidence is needed about successful implementation of regulation in developing countries.

Arguments for PHR*plus* Research on Regulation

There are a number of reasons why it is important for PHR*plus* to research the area of regulation of quality of care, particularly among private providers:

Need for better evidence on the actual impact and effectiveness of regulatory interventions in developing countries and need for improved understanding of the reasons for this, in order to be able to improve policies and strengthen technical assistance. In this proposed research, PHR*plus* will focus on developing more empirical evidence on how regulation works in developing

countries, and the determinants of successful regulation. Findings from the study will be relevant both to policymakers and technicians.

Continuous interest in this area by major donors. More developing countries are undergoing health sector reform initiatives, including strengthening the role of government in regulation. While donors have repeatedly discussed the need for effective regulation, none have been able to provide concrete advice about how to achieve this. The renewed focus on government's stewardship role also raises the profile of this area.

Build on previous PHR work. Work conducted under PHR included the development of regulatory programs and building of local capacity for regulatory implementation. It is important at this stage of the *PHRplus* to further our understanding and examine the factors that will contribute to the sustainability of these programs. *PHRplus* provides the opportunity for developing technical assistance activities in the area of regulation in Jordan, Albania, and Honduras.

Research Questions

The core question to be addressed by *PHRplus* research in this area is: What are the binding constraints upon effective regulatory implementation in developing countries? As a first step in addressing this question, *PHRplus* will develop a conceptual framework that will identify the different types of factors affecting the success of regulatory implementation. Initial thinking on this topic suggests a number of different factors:

A. Contextual factors

1. **Medical ethics** (professional interest/self-esteem and preservation of the medical profession) and its impact on regulatory enforcement. Regulation of the health sector is heavily influenced by individuals and group self-interests. The following questions may be addressed:
 - ▲ What aspects of medical ethics influence the relative success or failure of regulatory interventions?
 - ▲ To what extent do self-regulating professional bodies limit or support regulation due to professional biases?
 - ▲ What role do professional organizations play in regulation in developing countries and how should their role be strengthened, if at all?
 - ▲ What is the relationship between the health system structure in developing countries and the role that professional organizations play as regulatory bodies (for example, does the role vary as purchasing functions become more concentrated)?
2. **Trust and accountability.** It is unclear to what extent providers' trust in the regulatory system (and the government that supports it) and the accountability of the system impact regulatory enforcement. It is important to explore this research area because of the assumption that if providers do not trust government, they will be unlikely to trust a government-run regulatory system and will try to evade regulation. The research will explore these important factors further and will focus on the following questions:

- ▲ What are the factors that influence providers' trust in the regulatory process and the government that supports it?
- ▲ To what extent does providers' trust in the regulatory process influence successful regulatory enforcement?
- ▲ How can accountability and legitimacy of regulatory systems be defined and achieved in developing countries?

B. Capacity of Regulatory Organization

3. Institutional capacity. Successful enforcement of regulation requires strong systems with adequate resources (both human and financial). Such capacities are often beyond the institutional capabilities of developing countries. This research will attempt to study the following questions:

- ▲ What are the key human, financial, and other organizational components essential for developing a functioning regulatory system in developing countries?
- ▲ What mechanisms can the public sector use to strengthen its capacity in regulation?
- ▲ What role can the private sector play in regulation to fill some of the institutional and capacity gaps of the public sector?

4. Availability of meaningful standards. The availability of specific, meaningful, and up-to-date standards is essential for the effective enforcement of regulation. This research will examine the following questions:

- ▲ How can meaningful standards influence the successful implementation of regulations?
- ▲ What role can professional organizations play in developing standards and what coordination is needed with the public sector to define roles and responsibilities between the two sectors?

C. Capacity of providers

5. Capacity of providers to translate external regulations into internal actions. Changes in regulation may require providers to exert changes in their internal management structure and operation, in preparation for new regulations. To this end, the research will attempt to assess the capacity of providers to respond to external regulations by introducing completely new alternatives or modifying existing internal management systems. More specifically, the research will attempt to study the following questions:

- ▲ What is the impact of regulation on the internal management of providers?
- ▲ What mechanisms do hospital managers have to focus individual providers on regulatory requirements?

An important final piece to this research will be to explore the factors that should be included in the design of the regulatory system to ensure alignment of regulatory goals and objectives with provider motivation. Specific contextual and capacity factors may be more conducive to provider's

commitment and their support of the regulation. This research will attempt to identify these factors along with provider motivation to ensure appropriate implementation of regulation.

Next Steps/Research Approach

- ▲ Develop conceptual paper mapping out different factors that affect success of regulatory implementation.
- ▲ Building upon conceptual framework paper, develop a checklist that could be used in a country setting to help identify binding constraints upon regulatory implementation.
- ▲ Apply this checklist in pilot tests.
- ▲ Based on the results of the in-country testing, and if the checklist proves useful, develop a tool to assist policymakers in identifying key factors that should be addressed in the development and implementation of regulation.
- ▲ Building upon the situation assessment in-country, i.e., application of the checklist, identify one or two specific areas (e.g., professional ethics, capacity of regulatory institution) in which to develop more in-depth operational research.
- ▲ Select and further define the research questions.
- ▲ Work with technical staff to identify the country programs where the research activity could be conducted and further refine proposed research agenda to meet the needs of the specific countries.
- ▲ Develop detailed research protocols in collaboration with field staff.

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5. Health Worker Motivation in Reform Contexts

Lynne Franco

Background

Effective health service delivery requires the efficient use of the skills of a well-motivated health sector workforce. Evidence of poor worker motivation can be seen across countries at different levels of development. Motivational problems at work may show themselves in many ways, but common manifestations include lack of courtesy to patients; failure to turn up at work on time and high levels of absenteeism; and poor quality of care provided.

Health sector performance is critically dependent on worker motivation. Health care is highly labor-intensive, and, thus, service quality, efficiency, and equity are all directly mediated by workers' willingness to apply themselves to their tasks. Motivational problems among health staff not only negatively affect quality of care but have also been shown to reduce utilization of priority services. While worker performance is dependent on or limited by resource availability and worker competencies, the presence of these factors is not sufficient in themselves to ensure desired worker performance. Worker performance is also dependent on the workers' willingness to come to work regularly, work diligently, be flexible, and carry out the necessary tasks.

A renewed interest and effort is being made worldwide on human resource management (WHO, PAHO, USAID, World Bank), and motivation is a key component in health workforce performance. Dr. Jim Buchan, during a presentation on human resource management at USAID (September 2001), talked about the fragmented evidence base on effective strategies to improve human resource management and health worker performance. One key area he mentioned was incentives and motivation, and he stressed that this is one area of human resource management that has some flexibility for intervention.

Discussions with PHR*plus* technical assistance staff indicated that lack of health worker motivation may be a particular barrier to successful reform implementation. This is frequently the case, for example, with hospital autonomy.

Current State of Knowledge

Improving health worker motivation requires information about key determinants of motivation and about potential effective interventions to address those determinants. Research in industrialized countries has identified key motivational determinants and there is some evidence base on the effectiveness of various interventions. However, information about which determinants are key in developing country settings is not readily available. Research efforts have tended to focus on determinants of job satisfaction, but not much on job performance and quality.

Major applied research work under PHR explored the determinants and outcomes of health worker motivation in Georgia and Jordan, and indicated that broader cultural and contextual factors have a large influence on which determinants are key and how they affect various subgroups of the workforce. Study findings highlighted potential areas for intervention (for example, perception of self-efficacy, management openness, pride, and job properties had a significant impact upon motivation in both countries studied), but did not suggest specific interventions, leaving this to hospital managers to work out. In addition, the timeframe for the applied research conducted under PHR did not allow for implementation of interventions designed to improve health worker motivation.

Arguments for PHRplus Research on Health Worker Motivation

Importance of Topic: Health worker motivation, or lack of motivation, is one critical component in health systems performance. Increasing interest by other international agencies in the area of human resource management and the lack of a good evidence base for best practices related to health worker motivation point to the urgency of this topic area.

Need for more empirical evidence: Currently, the published literature is very scarce on either what determines health worker motivation in developing and transition countries, or what interventions are most effective for increasing or maintaining worker motivation. PHR applied research in this area indicated contextual differences between the Middle East and Eastern Europe, and, while there are no data as yet, these indicate there would also be differences between and within Africa, Latin America, and Asia.

PHR track record in this area: PHR has already conducted ground-breaking conceptual work and field research in this area, and has worked collaboratively with other researchers to develop common research agendas.

Research Questions

Research activities should focus on creating an evidence base for interventions that can effectively and efficiently improve and maintain worker motivation in developing and transition countries and in particular in reform contexts. To develop such evidence base will require:

1. Development of a conceptual framework for the identification of potential interventions that address key determinants of motivation;
2. Refinement of measurement tools for baseline and evaluation of impact of interventions on key determinants and outcomes of worker motivation;
3. Creation of research sites where interventions to improve motivation can be developed and tested.

Conceptual framework for linking determinants of motivation to interventions

In order to move forward on creating an evidence base on effective interventions for improving health worker motivation, the development of a conceptual framework document is suggested that outlines how managers and policymakers can move from results on what motivates health workers to the development and testing of interventions. Results from the Georgia and Jordan studies indicate that potential areas for intervention should focus on improving perception of self-efficacy,

management openness, pride, and job properties. Possible interventions could include but would not be limited to improved communication, better job design, increased accountability, better recruitment and selection procedures, better worker orientation to their job and organization, improved leadership and teamwork, stronger links to the community, and opportunities for community feedback.

Specific activities for the development of the conceptual framework include:

- ▲ Review literature on organizational and industrial psychology, performance management, and human resource management for conceptual frameworks and research that links determinants to interventions;
- ▲ Develop a framework appropriate to our work in developing countries;
- ▲ Draft paper that would build on PHR's first conceptual framework on health worker motivation and health sector reforms (Bennett and Franco 1999), research results, and the literature to identify potentially effective interventions for addressing the range of motivational problems;
- ▲ Do external review of paper;
- ▲ Revise and produce final paper for publication under *PHRplus* and article for submission to a journal.

Refinement of HWM tools and methods, and publication as a set of “tools”

Although PHR did a self-critique of the methods used in its Major Applied Research activity, no further work has gone on to refine and improve these tools, based on project experience using them. *PHRplus* has already received requests for copies of the research protocol and research instruments used to conduct the PHR work on health worker motivation. The refinement process will include:

- ▲ Review all research instruments previously used for gaps or scales that did not work well for possible modifications and additions;
- ▲ Conduct limited literature review to identify possible alternative or additional scales;
- ▲ Review research methodology for possible simplifications;
- ▲ Develop brief set of guidelines for researchers wishing to use the methods and instruments, including how to adapt to the local environment, and advice on sampling, implementation and analysis.

This package of tools will then be available for the measurement of baseline (and data for design) and evaluation of interventions to improve health worker motivation.

Test the effectiveness and efficiency of interventions to improve worker motivation in reform contexts

Sites for field research could be identified within *PHRplus* countries or with other projects and agencies working on this issue. Such fieldwork would include:

- ▲ Baseline data collection on key determinants and outcome levels of worker motivation;

- ▲ Workshop or other consensus building format to choose interventions or reform designs to implement and evaluate (test);
- ▲ Design and implementation of interventions (by facility managers, sub-national bodies, Ministries of Health, Civil Service Commissions, etc);
- ▲ Evaluation data collection to assess impact on key motivational determinants and on motivational outcomes (performance, satisfaction/commitment, cognitive motivation).

Such fieldwork may require certain coordination/collaboration mechanisms which would allow *PHRplus* to both contribute the technical expertise it has developed in measuring determinants and outcomes of motivation in developing and transition countries and benefit from the evidence base created by such studies that are done outside the direct *PHRplus* context.

Next Steps in Developing This Research Area

1. Develop Technical Direction to authorize expenditures.
2. Continue and expand contacts with organizations working on health worker motivation and related topics (WHO, PAHO, World Bank, Liverpool School of Tropical Medicine, etc.)
3. Commence work on refinement of tools.
4. Initiate work on conceptual framework for interventions to improve motivation.
5. Explore opportunities for health worker motivation intervention research within all *PHRplus* activities and with other organizations and projects.

Annex A: Questionnaire Used with Policymakers

PHR*plus* **Applied Research Questionnaire**

Introduction

PHR*plus* is now in the process of developing our five-year applied research agenda and we seek your feedback on what research areas we should prioritize.

Your opinions, together with other inputs such as consultations with USAID, international organizations, as well as with other developing country researchers and policymakers, will be used to develop an applied research agenda, as well as to select the topics that most urgently need to be addressed. This agenda would be used by the project, the Global Bureau and the international research community more broadly. We would be delighted to share a copy of this research agenda with you, if you were interested (a question at the end of the survey allows you to indicate this).

We would be most grateful if you could take the time to complete the brief questionnaire attached. Although the questionnaire is several pages long it takes on average 10-15 minutes to complete. Your contribution is of course entirely voluntary.

Thank you

September 2001

A. Research Priorities

The PHR*plus* project is tasked to work in a number of different areas including ensuring effective policy implementation, health care financing, quality of care, health system management, and health information. Our work in each of these areas focuses upon improving the performance of USAID priority services: child health, maternal health, HIV/AIDS, and infectious diseases.

Thinking about the country where you live we would like you to (a) grade the overall importance of research on the broad topic area (in bold) and (b) grade the importance and relevance of the individual research questions identified. At the end of each section there is a blank space for further comments. If you have specific ideas about the kind of applied research that you would like to see conducted then we encourage you to provide these details here.

Please grade the importance of the various research areas using a five-point scale from (1) very unimportant to (5) very important.

1	2	3	4	5
Very unimportant	Unimportant	Neither important nor unimportant	Important	Very important

- | | |
|---|---|
| 1. Policy development in health system strengthening | ✓ |
| 2. Changing roles of ministries of health: the development of new capacities. | ✓ |
| 3. Accountability to consumers within the health care system | ✓ |
| 4. Impacts and processes of sector-wide adjustment programs (SWAPS) | ✓ |
| 5. Impact of Highly Indebted Poor Country (HIPC) debt relief strategies and Poverty Reduction Strategy Papers (PRSPs) on health systems | ✓ |
| 6. Sequencing of health sector reform | ✓ |
| 7. Impacts and processes of global trust funds | ✓ |

Further comments about research on policy development in health system strengthening:

- | | |
|--|----|
| 8. Health Care Financing | \\ |
| 9. Community-Based Health Insurance Schemes | \\ |
| 10. User fees (including effects of repealing user fees) | \\ |
| 11. Protecting access for the poor: exemption mechanisms and subsidies | \\ |

1	2	3	4	5
Very unimportant	Unimportant	Neither important nor unimportant	Important	Very important

12. Social health insurance \ \

13. Insurance regulation \ \

14. Equity of health care financing \ \

15. Informal (“under-the-table”) payments \ \

16. Provider payment mechanisms \ \

17. Contracting for health care \ \

Further comments about research on health care financing:

18. Organization and management of health care \ \

19. The impact of decentralization upon PHN priority services \ \

20. Factors contributing to effective public/private partnerships \ \

21. Autonomous hospitals \ \

22. Public and private roles in health care commodity markets \ \

Further comments about research on organization and management of health care:

23. Quality of care \ \

24. Approaches to stimulating health worker motivation \ \

25. Strengthening regulation of private health care providers \ \

26. Commodities and distribution systems \ \

27. Approaches to improving quality of care e.g., accreditation \ \

28. Health system responsiveness: dignity, promptness, amenities, choice \ \

Further comments about research on quality of care:

1	2	3	4	5
Very unimportant	Unimportant	Neither important nor unimportant	Important	Very important

29. Family planning services in relation to health system strengthening \ \

30. Efficiency and sustainability of family planning services \ \

31. Pricing family planning services and ensuring accessibility for the poor \ \

32. The role of the private sector in the provision of family planning services \ \

33. Family planning service quality and responsiveness, and program outcomes \ \

Further comments about research on family planning services in relation to health system strengthening:

34. Child health and health system strengthening \ \

35. Financial sustainability of immunization \ \

36. Funding the introduction of new vaccines \ \

37. System strengthening for Integrated Management of Childhood Illness (IMCI) \ \

38. Access for the poor to child health services \ \

Further comments about research on child health and health system strengthening:

39. Maternal health in relation to health system strengthening \ \

40. Alternative financing mechanisms for maternal health services \ \

41. Mechanisms (financial and other) to promote access for the poor to safe motherhood services \ \

42. Referral networks for expanding skilled attendance at deliveries \ \

43. Cost-benefit analyses of different maternal health services (e.g., skilled attendance at birth, post-partum care, treatment of obstetric complications) \ \

Further comments about research on maternal health in relation to health system strengthening:

1	2	3	4	5
Very unimportant	Unimportant	Neither important nor unimportant	Important	Very important

44. HIV/AIDS in relation to health system strengthening \ \

45. Health system capacity constraints upon the delivery of ARV \ \

46. Sources (donors, government, etc) and uses of HIV/AIDS financing \ \

47. Retention and motivation of health workers in high HIV/AIDS contexts \ \

48. Community-based health insurance and sero-positive individuals \ \

49. Effectiveness of NGOs in reaching marginalized HIV/AIDS populations \ \

50. Cost effectiveness of alternative approaches to reduce maternal to child transmission of HIV \ \

51. Implications for the health care system of the HIV burden \ \

Further comments about research on research on HIV/AIDS in relation to health system strengthening:

52. Infectious diseases, disease surveillance in relation to health system strengthening \ \

53. Information dissemination and use of information in health service planning and management \ \

54. Community roles in disease surveillance systems \ \

55. Best practices in health information system development \ \

56. Disease surveillance in the context of decentralized health care systems \ \

Further comments about research on infectious diseases, disease surveillance in relation to health system strengthening:

57. Please indicate any further research ideas that you may have:

B. The potential for research in your country

We would be grateful if you would answer the questions below regarding potential for research in your country. Please be assured that your responses to these questions do not constitute any commitment on your part.

58. Would you be interested in having *PHRplus* conduct any of the research topics identified above in the country where you currently work? Yes ☐ No ☐

If "Yes," please identify the areas in which you would be most interested for *PHRplus* to conduct applied research:

59. Are there any health system researchers (individuals or institutions) in the country where you work whom you think it would be useful for *PHRplus* to collaborate with?

If "Yes," please provide names and contact details:

C. About you

Finally we would like to ask some basic information about you, to help us compile all responses, and also follow-up with you if necessary.

60. Your name

61. Your current position

62. Organization for which you work

63. Country from which you come

64. Email address

65. Would you like to receive a copy of the research agenda? Yes ☐ No ☐

THANK YOU VERY MUCH INDEED FOR YOUR TIME AND IMPORTANT INPUTS INTO THIS PROCESS.